

**Beneficence, Boundaries and Big Brother: Patients'  
and Doctors' Construction of 'Personal Care' in  
General Practice Medicine**

**Rachel Pirrie Adam**

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# **DECLARATION**

I declare that this thesis is entirely my own work and that it has been submitted only for the degree of Ph.D.

Rachel Adam

10-12-2002



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## ABSTRACT

This study arises from widely-voiced concerns within academic and professional communities that changes, mainly in the organization of the NHS, have placed the future of 'personal care' in General Practice in doubt. Personal care may be considered one of the foundational, core values of the profession's ontology and its claim for specialist status. However, the concept of the personal has only an underlying and taken-for-granted presence in most related thinking and empirical research, and has been implicitly conceptualized in a myriad of ways. There is a paucity of research that has either explored 'the personal' as a socially constructed concept or attempted to understand lay perspectives of it.

Using a qualitative methodology, twenty-three patients, mainly women with young children, and twenty-three General Practitioners (GPs) from the Lothian Health Board area of Scotland were interviewed to explore their understandings and experiences of personal care in General Practice. Patients' and GPs' accounts were strikingly similar and suggest that they were embedded in, and drew upon, a wider discourse of bio-psychosocial medicine. Personal care was constructed as multi-faceted; as the patient-doctor relationship built over time, characterized by *mutual knowing* and *mutual trust*, in which the doctor shows a particular consultation style. Interviewees placed significant importance on such care and attributed numerous specific benefits to it. For patients, personal care could be seen as allowing the establishment and maintenance of a legitimate identity that smoothes their path into and through health care

systems and as helping to optimise their health status. For doctors, it enshrined the 'spirit of generosity' of care, whilst also permitting identification and control of the 'problematic' patient. However, the level of importance interviewees placed upon personal care was contingent upon attendant circumstances. They also felt it could be disadvantageous and placed boundaries around it.

These findings are considered in relation to sociological theories on the patient-doctor relationship. The later work of Foucault on the *practices* or *technologies of the self* is found to provide the most adequate understanding of the data's complexity. The findings are also considered in the light of recent and proposed policy developments within primary care, particularly the NHS plans for Scotland and England and the proposed new GP contract for the UK. The thesis concludes that personal care has continuing salience for, at the very least, some patients and doctors in certain contexts and should be preserved within the new organization of primary care services.

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# CHAPTER ONE

## Introduction

*'Increasingly, the emphasis in general practice is focusing not on the doctor, the patient, and his or her illness, but on the practice, the population, and its morbidity. There can be no doubt that general practice... is burdened with increasing amounts of work... The pot is brimming over. What has spilled out is the time-honoured personal care' (Taylor, 1997: 521).*

### The Erosion of 'Personal Care' in General Practice

This study arises from widely-voiced concerns in academic and medical practitioner communities that changes in society in general, and those within the organization of the NHS in particular, have placed the future of 'personal care' in General Practice in doubt. Some writers are predicting the death of the 'personal doctor'. For example, Taylor (1997), quoted above, laments the passing of care with a 'personal' quality. He argues strongly in favour of the 'unquantifiable' value of the doctor's compassion for the patient being preserved in the face of changes to primary care services, and against the concomitant transformation of the General Practitioner's (GP's) role in such services. It is argued that such changes have overloaded doctors and what is being lost is the tradition of personal care.

The main societal change often suggested as contributing to the demise of personal care is the expansion of 'consumerism' as a force in modern British

society. In this respect, consumerism has become the subject of much commentary and debate (Lupton *et al.*, 1991 and 1997; Rose and Bateman, 2001; Davies, 2002). Indeed, the NHS Service Delivery and Organization Research and Delivery Programme [NCCSDO] report on access to healthcare notes that *'there is an increase in a consumerist approach to the NHS within a context of increasing demand for services'* (NCCSDO, 2001 b: 1 and 99). Within this debate, consumerism is usually defined as patients demanding access to twenty-four hour health care from the first available practitioner, rather than care provided by the usual, known and trusted practitioner (British Medical Association [BMA], 2000: 2). In some General Practice literature, the NHS response to these so-called consumerist demands has been somewhat dismissively referred to as resulting in *'Tesco medicine'* (Taylor, 2001).

Recent organizational changes within the NHS considered to threaten the continued existence of personal care include: changes to improve speed of access into primary care services and between primary and secondary care sectors; growth in the number of large, multi-professional practices and in multi-team working; and the incursion of a public health agenda into primary care leading to specialization of services for the management of chronic conditions, as reflected in national clinical standards set through a regimen of Clinical Governance in the form of Evidence Based Medicine (EBM). The Scottish NHS plan, *Our National Health: A plan for action, a plan for change* (Scottish Executive, 2001) and its English equivalent, *A Plan for investment, A Plan for reform* (Department of Health, 2000) have consolidated and taken forward these policy shifts. I now consider each of these in turn.

In Scotland, a commitment has been made to provide access within forty-eight hours to an '*appropriate*' practitioner, based on clinical need. In England, forty-eight hour access to the first available GP is promised. In addition, most GPs have organized themselves into Out of Hours Co-Operatives that provide emergency care outside normal surgery hours, and these are to be rolled out across the country (Heaney and Gorman, 1996; Hopton and Heaney, 1999). Scottish NHS 24 and the English counterpart NHS Direct are designed to provide quick access to patients on a twenty-four hour basis (Munro *et al.*, 2000; Grant *et al.*, 2002). Walk-in centres are being developed in England (Salisbury *et al.*, 2002). On-line access is an addition to such services in the UK ([www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk)). These services are supplementary to those provided by practices during regular hours. Many are nurse-led and aim to expand and better use the skills of nursing staff.

There has also been a trend away from single-handed and small practices towards larger practices and health centres. This trend is supported by both NHS plans that explicitly encourage a move to larger, multi-professional teams offering integrated care. Indeed, overall, the primary care team has expanded with an associated emphasis on a whole team approach. Multi-team working is particularly promoted for the management of chronic conditions such as ischaemic heart disease, diabetes, asthma, hypertension and osteoarthritis. GPs are asked to concentrate on serious illness, whilst allied staff deal with less serious, every-day problems.

In addition, the increased use of the community pharmacist has been promoted to deal with minor illness in the community and reduce demand on GPs and other practice staff (Hassel, 2001). There is a general move toward the extension of the roles and responsibilities of allied primary care staff, in order to free GPs' time for those who really need their clinical skills (Royal College of General Practitioners [RCGP] *et al.*, 2001 a). All the above developments undermine the potential for the patient seeing a known doctor within normal surgery hours increasingly less likely and seeing a known doctor outside surgery hours remote.

Increasingly, primary care has been required to give priority to 'population medicine', such as child health surveillance, immunization and cytology. This role is expanding as this health sector is given a more central role in the prevention, detection and management of serious and chronic diseases, such as ischaemic heart disease, hypertension and diabetes. In order to meet these new standards, GPs are encouraged to take up specialist roles within their generic setting and poly-clinics are being developed to provide one-stop care to these patients in a community setting (Scottish Executive, 2001; RCGP, 2001; NCCSDO, 2001). These developments may present further barriers to patients seeing the known doctor.

Indeed, primary care medicine is increasingly expected to embrace and implement a public health agenda. National standards have been set to improve and equalize the quality of medical care across the UK (Scottish Executive, 2001; General Medical Council, 2002). A regimen of Clinical

Governance through Evidenced Based Medicine (EBM) is becoming more firmly embedded in order to achieve higher clinical standards in every part of the country. EBM is founded on actuarial calculations of risk at a population level (Murphy, 2000). It has become the new 'expert' knowledge and, given greater impetus by the NHS plans, is finding inroads into the everyday practices of primary care. Some concern has been expressed that the focus on EBM, driven by protocols, produces a standardized response to the disease, whoever the patient, and reduces the doctor's ability to treat the patient as an individual. Some perceive it to be a threat to the doctor's clinical autonomy and to the patient-centred, idiosyncratic medicine which many claim lies at the heart of General Practice medicine (Mackenzie, 2001; Oliver, 2001).

All these developments encourage the diffusion of care tasks across health care professionals and place an emphasis on speed of access to any service provider, in preference to the patient seeing the usual doctor. They may also result in a greater focus on the technical, bio-medical aspects of medicine rather than dealing with the 'person who has the illness'. In these respects, many policy shifts are thought to cut across the core values of General Practice, including personal care or 'continuity' of care. It is feared that personal care, usually characterized by the patient-doctor relationship or a 'patient-centred' consultation style, is being eroded. For instance, McCormick (1996) in a paper tellingly entitled, *'Death of the Personal Doctor'* claims:

*'... in the not too distant past General Practice often provided personal and continuing care; it was continuing care that allowed the possibility of knowing the person who has the disease. There is no doubt that, although the possibility of*

*continuing care remains, it has been eroded by the growth of group practices, duty rotas... It is also eroded by the growth of the team' (McCormick, 1996: 667).*

However, the NHS plans assert a commitment to retaining many of the core values usually associated with personal care that are considered sacred to the tradition of General Practice. The emphasis on speed of access to any health care practitioner, for instance, is not discussed as being prioritized *to the exclusion* of a patient's opportunity to see a known doctor. Patient-centred care, defined as eliciting the expressed needs and preferences of the patient, is emphasized and is to be at the centre of the planning, organization and delivery of health care. The plans also refer to delivering a service to the '*whole person*' and are concerned with the patient's experience of care by focusing on improvements to the '*pathways*' into care and the '*patient's journey*' through care. In these respects, the Scottish plan states:

*'People want a health service which listens, communicates and values them throughout their journey of care. Greater continuity of care, better information and improved access are key to achieving this' (Scottish Executive, 2001: 20).*

The NHS plans also note the need to preserve clinicians' right to autonomy to prescribe what is best for their individual patients within a framework of national guidelines and standards. The public health agenda, reflected in these national standards, is to be implemented at a local level in order that account is taken of the specific needs, current and future, of local populations and communities. Particular attention is to be paid to the issue of health inequalities in local communities.

The co-existence of core values alongside newer developments is also promoted by professional medical bodies, such as the Royal College of General Practitioners. In a series of papers responding to the plans, the RCGP notes:

*'Primary health care should continue to be at the heart of the NHS. General Practitioners are the patients' advocates; front-line diagnosticians; the keeper of the life-long record; the deliverer of continuity of care and are highly cost-efficient' (RCGP et al., 2001 a: 4).*

Such documents promote the continuation of a health service that is patient-centred and allows personal continuity of care with a known and trusted practitioner. Similarly, the British Medical Association (BMA), talking about the future of General Practice in the twenty-first century, states:

*'General Practice is a fundamental part of the health care system. At its centre is the care provided to people who are ill or believe themselves to be ill, and at its heart a doctor-patient relationship based on mutual trust and personal attention focused on the individual' (BMA, 2000: 1).*

Providing patient-centred care, tailored to the specific needs of the individual in the context of this relationship, continues to be a central plank of professional bodies' rhetoric and suffuses their proposals for health care practice. At the same time, these bodies also support many of the new developments including: improved access; expansion of the out-of-hours services; extension of the roles and responsibilities of primary care staff; implementation of national standards to erase variation of quality across the UK; and better prevention and

management of chronic disease in the community and the related trend toward GP specialization. The RCGP report, however, points out that GPs skills cannot be substituted by other members of the primary care team and that small practices can and do provide high quality care. It is also is uneasy that EBM may undermine the flexibility and individualized care that has been the hallmark of General Practice and expresses concern that this will be disadvantageous to patients:

*'Formulaic, protocol-driven care can undermine patient autonomy within the consultation'* (RCGP *et al.*, 2001 a: 9).

### **The Proposed New GP Contract**

Many of the aforementioned policy shifts have more recently been reflected in, and consolidated by, the proposed new GP contract (GMC, 2002). The contract sets out a system of rewards and incentives that take forward many aspects of the agenda of the NHS plans including: expansion of the out-of-hours system to give all GPs the choice to opt out of twenty-four hour care; speed of access to any health care practitioner; growth of multi-professional practices and the siphoning-off of minor, self-limiting illness and chronic disease management to nursing staff; GP specialization; and increasing emphasis on a public health agenda and improved country-wide standards through Clinical Governance in the form of EBM. Principally, the contract focuses on how to relieve doctors of dealing with more everyday problems through appropriate delegation to allied staff, so that doctors' particular clinical skills may be more fully and most efficaciously used.



Services have been categorized into three levels in order that financial incentives can be put in place for GPs:

*'... to control their workload without damaging patient care [and to have a mechanism that makes funds]... "future-proofed", so that any new work [is] fully resourced' (GMC, 2002: 8).*

The categorization splits medical work into *essential clinical services*, *additional clinical services* and *enhanced clinical services*. Essential services constitute the core work of all practices already offered, and this section of the contract continues primary care's universal provision of care. Additional services constitute the public health agenda and include vaccination and immunisation, child health surveillance, contraception, cervical cytology and chronic disease management. Additional services are to be provided by most practices with opting in as the default position, but practices may make a case in exceptional circumstances to opt out. Both essential and additional services are to be provided by most practices and will be priced nationally. Enhanced services at both a national and local level are to provide specialist services, such as treatment for minor injury or services to violent patients. National services are to be made available in every locality, but will not be offered by every practice. Though the price is nationally agreed, these services are to be locally commissioned. The default position is that practices opt in to providing enhanced services. Local enhanced services are intended to reflect the area need and, so, are to be subject to local discretion. The price is not set nationally and must be agreed at a local level.

Guaranteed funding for essential and any additional services will be provided from a global sum based on the weighted needs of the practice's patient list. Details of the monies involved are still to be announced. Patients are no longer to be registered with an individual GP but with a practice, indicating the emphasis on whole practice care that is to be consolidated by this system of financial rewards. This reflects the practice of most doctors at the current time, but will make it a dictated practice across the UK. Funds for both additional and enhanced services are to be dedicated to their specified use, thus ring-fencing funding for all new work. The other main source of income for primary care is associated with a new quality and outcomes framework. In essence, the level of these payments is to be linked to a measured level of quality which will be audited at least once in every three years.

The contract proposes that quality-of-care markers are to be evidence-based. They include some aspects of practice infrastructure, such as provision of disabled toilets and having a health and safety policy. However, the main thrust of this incentive scheme is directed at achieving clinical improvements in the management of major chronic diseases, mentioned above. These improvements are to be measured by the practice's adherence to 'best practice', determined by EBM, such as giving healthy lifestyle advice, providing 'clinically proven' medication and carrying out regular reviews of medication. Regular bio-medical tests are to be given and details of such recorded to provide evidence of improved health outcomes for the auditing process.

It is clear that the proposed new contract incentivizes primary care to tackle a public health agenda by encouraging an emphasis on the prevention, detection and management of disease. This is further reflected in the career development funds to be made available for GPs to take up clinical specialisms like minor injury, chronic disease management and hospital practice, so that these skills become more integral to General Practice and are no longer an 'add-on'. They also include encouraging GPs to take up other non-clinical special interests, such as research, training and teaching, and management roles in primary care organizations. Specialization has been largely welcomed, with some caveats, by the Royal College of General Practitioners (2001). More part-time and flexible working practices are also being encouraged with support from professional bodies.

The new GP contract, if adopted, will dilute the possibility of personal continuity with one carer as care tasks are diffused across a multi-professional team and practitioners become less available both in the short- and long-term. In this respect, the contract mirrors the NHS plans. However, curiously absent from the contract are many of the traditional values of continuity, patient-centred medicine and 'whole person' care which the plans promote. Indeed, concern has been expressed that the contract, if implemented, will ring the final death knell for the personal doctor (McArthur, 2002; Leuty, 2002; Rickenbach, 2002).

## The Place of Personal Care in the Tradition of General Practice

The significance to GPs of the many recent policy changes and the proposed new GP contract, and the fears they have given rise to, must be considered within the context of the profession's history and its claim to professional identity. Care with a personal component is deeply rooted in the tradition of General Practice. It is recurrently cited in the literature as the bedrock of the profession, to the extent that such care is arguably a central feature of how it defines itself (Berger, 1969; Loudon *et al.*, 1998; McWhinney, 1998). Writing about the core values of General Practice, for instance, McWhinney states:

*'... for most of this century, the typical primary care professional has been a generalist practitioner, usually practising close to the population served by the practice, alone or in a small group, and supported by a small staff... . The key relationship for most of these practitioners is with individual patients who consult about problems they have identified themselves... For all its limitations, General Practice has represented a strong tradition of personal care, comprehensive in its response to the needs of the people and reasonably accessible in their neighbourhoods and homes' (McWhinney, 1998: 1807).*

Indeed, this emphasis on the personal, as distinguished from technical aspects of care, has evolved as General Practice itself has developed, such that it is now regarded as the very foundation of the profession. By technical aspects of care, I mean care that is based entirely on a bio-medical model and, so, does not emphasize regard for the patient as a subjective being with needs beyond the strictly physiological.

The concept of personal care is so central to General Practice's ontology that it is synonymous with what it means to be a 'good' doctor offering 'high quality' care. Indeed, it arguably marks out General Practice's professional territory, so allowing it to distinguish itself from other areas of medicine (Bower and Mead, 1998; May and Mead, 1999). Keeley, for instance, in noting the disadvantages of the above developments in primary care, refers to '*personal and continuing care [as being] held to be the cornerstone of good General Practice*' (Keeley, 1991: 1515). Because GPs have constructed themselves in relation to the concept of the personal, in effect, it has become the specialism of General Practice. The personal is regarded as the profession's 'gold standard', with various conceptualizations of it being used as proxy measures for quality of care (Mead and Bower, 2000).

Further, the inclusion of the notion of the personal in medical care appears to be of importance not only to GPs themselves but also to patients. In a number of empirical studies, when asked what they valued most about care from the GP, patients regularly give a high priority to qualities usually associated with personal care. These include seeing the same doctor over time, being recognized by practice staff, and having a doctor who listens (Smith and Armstrong, 1989; Al-Bashir and Armstrong 1990; Grol *et al.*, 1999). There is other empirical evidence that patients place value on care with a personal component, but that the level varies according to patient grouping (Freeman and Richards, 1990; Al-Bashir and Armstrong, 1990; Baker and Streatfield, 1995; Baker, 1997).

However, despite the significance of personal care in the history and ontology of General Practice, and the value it appears to hold for at least some patients, what personal care actually *means* to patients and General Practitioners themselves is an area of work that has been neglected. Likewise, the value and importance personal care may hold for patients in the context of their everyday lives, and for doctors as service providers, has rarely been subject to scrutiny. The exception to this is the work of Preston *et al.* (2001), which makes a significant contribution methodologically and substantively to this area of research, but which stops short at exploring it empirically as a *socially constructed* concept and theorizing about it in these terms.

The irony that lay accounts of the concept, in particular, are notable by their absence is significant, given General Practice's stated commitment to the primacy of the patient's perspective and the current emphasis the NHS and professional bodies place on patient 'partnership' in setting priorities and developing services (Richards, 1999; Scottish Executive, 2001; RGCP, 2001 a; Department of Health, 2001).

Thus, the impetus and timing of this study should be seen as emerging from, and in response to, recent changes in the organization of primary care, and the evolution of the GP's role in services. In particular, it was incited by the debate about the threat to the continued existence of personal care, which the profession of General Practice claims has been fundamental to their professional ontology and practice and which, it seems, at least some patients highly value. The specific focus of the study arises from the identified gaps in empirically-

based work on personal care as a socially constructed concept and the notable absence of lay and General Practitioners' accounts in this area. The study, therefore, is located within, and materializes from, this wider historical and organizational context and responds specifically to this lacuna.

## **Structure and Aims of the Thesis**

The current chapter sets out the background and policy context to this thesis, as above. I now summarize the main points contained in each of the following chapters.

The literature review in *Chapter Two* shows that personal care in General Practice has been treated as axiomatic rather than problematic in most research; i.e. as a taken-for-granted concept and, thus, as having *a priori* meaning. The chapter demonstrates that there is a paucity of work which has considered the personal as *socially constructed*, and people's common sense understandings have rarely been explored. It also highlights the tendency to focus instead on areas of work that encapsulate some notion of the personal as an underlying theme and, so, to have an implicit presence in related areas of primary care research. The literature background to the study of the meaning and importance of personal care in General Practice is, therefore, inevitably tangential and rather diverse.

In the review, I outline two bodies of work that have incorporated some notion of the personal in primary care, which are relevant to this thesis. The first springs predominantly from health services-oriented research. Often based in

University Departments of General Practice, this tends to have a practice and policy focus. Reviewing this work allows me to delineate the main ways the concept of the personal has typically and implicitly been conceptualized. I also summarize the substantive findings of these studies as this thesis makes a contribution to the evidence in this respect. However, this body of work is inconclusive and contradictory and does not provide an adequate framework within which to understand the study data.

Thus, I also consider the body of literature on sociological theorizing and empirical work on the patient-doctor relationship because this is the main way that interviewees talked about what personal care means to them. I summarize the main sociological perspectives, discuss briefly how they have been critiqued and consider their merits in bringing an understanding to this thesis. In particular, I consider the work of Foucault whose thesis examines the personal as a concept explicitly. Relatively speaking, this literature is more theoretical in nature. It also allows insight to how the personal has been implicitly conceptualized, and several important themes that have emerged from these data can be usefully explored and understood through reference to it.

Further, the review provides evidence that research usually has used working definitions of personal care that are researcher-driven rather than derived from patients themselves. This contention is supported by the recent Research & Development (NCCSDO) Scoping Exercise of Continuity of Care, the report of which concludes that:



*'Research on the patient's perspective has been relatively neglected in most of these studies, even though most of them profess to be "patient-centred" or "patient-oriented"'*  
(NCCSDO, 2001 a: 30).

The report shares my own concern that this area of health care research has failed to ensure that the views of service users are obtained in order to shape services (NCCSDO, 2001 a: 3). Given these gaps in literature and, in particular, the lack of patients' accounts of what personal care in General Practice means to them, this thesis explores the concept by examining two key research questions:

1. How do patients and doctors construct the meaning of personal care in General Practice?
2. What importance and value, if any, do patients and doctors place on personal care, and in what contexts?

In attending to these two research questions, this thesis differs from previous work reviewed in this chapter in that it examines the meanings that patients and doctors attributed to the concept of the personal in care, and the importance and value it was said to hold in their everyday circumstances. It is also distinguished by comparing patients' and doctors' accounts of personal care against the variables of practice size and deprivation score, as I discuss in Chapter Three. Further, it focuses on the concept of the personal in a UK General Practice context, taking account of the recent and proposed policy developments of health services within that context.

In *Chapter Three*, I outline the epistemological and methodological approaches adopted in this study, as well as details of the study design. I particularly comment on the epistemological status I am attributing to the interview data. I discuss how the study's emphasis on seeking interviewees' understandings of the concept of the personal, and any salience it may hold for them in the context of their everyday lives, is central to the study design and approach taken to data analysis.

Twenty-three patients and twenty-three doctors were interviewed using a semi-structured interview guide. In order to allow patients time to reflect on the concept of personal care that may have had little salience to them, they were interviewed twice with a gap of around two weeks. Given its relevance to professional bodies, the concept was likely to have more immediate salience to doctors, and because interviews were more difficult to arrange, they were only interviewed once. Interviewees were drawn from a sample of practices in the Lothian Health Board area, using practice size and deprivation scores as variables for selection. All the patients were parents with children aged ten and under and this criteria reflects my own particular interest in families and children. Only parents were interviewed, although they were asked about the health care of their children. I sought to interview all doctors from each of the selected practices in order to recruit a sufficient number of doctors without involving too many practices.

All interviews were recorded, with participants' consent, and were fully transcribed. The data were analyzed thematically using the qualitative analysis

software, NVivo, and more traditional paper-based methods. The analysis and subsequent theorizing were focused on the views and experiences of patients. Moving between the analyses of the two data-sets, it became apparent that the broad themes discussed by patients and doctors were very similar. I, therefore, emphasize patients' accounts in this thesis and only present doctors' in order to compare for similarities and differences. Patients' accounts have been privileged to avoid unnecessary repetition of the main themes and due to the absence of their voice from much previous debate and research in this important area of work. Further, I discuss the ways in which I was reflective and reflexive in carrying out the study.

*Chapters Four to Six* report on the findings of the study. *Chapter Four* deals with the first research question and describes how interviewees talked about what personal care means to them. Interviewees talked about personal care in three distinctive, but not mutually exclusive ways: as care that relates to the practitioner's consultation style within each medical encounter; as care that is given by the whole practice and, predominantly, as care that occurs within a patient-doctor relationship built over time, characterized by '*mutual knowing*' and '*mutual trust*'. For most interviewees, for care to be personal, it had to include both a particular consultation style and a temporal component. In effect, when talking about personal care, interviewees were adopting and drawing on a bio-psychosocial discourse of General Practice medicine and this discourse suffused all aspects of the study data.

*Chapter Five* does not deal with a pre-set research question, instead it discusses the significant themes of *mutual knowing* and *mutual trust* that emerged from the analysis of the meaning of personal care. Interviewees talked about knowing and being known in two main ways; what I have called 'factual knowledge' and 'interpersonal knowledge'. Interviewees talked about factual knowledge in relation to three main spheres of information as being legitimate, and sometimes even necessary, to the provision of personal, and so to good care. Interpersonal knowledge is shown to be distinctive from the doctor holding 'facts', but is of equivalent importance in the data. Trust was talked about as being mutual and was defined in two ways; what I have called *de facto* and *experiential*, with the latter being the most widely drawn on concept of trust when discussing personal care. A main, recurrent theme in patients' accounts was that personal care enabled them to be known in *a particular way*; as having a moral identity as legitimate and trustworthy patients and parents with a deserving claim to service.

However, interviewees also raised concerns or potential problems when discussing personal care and knowing and being known as a central aspect of this. Boundaries were placed by patients around the level of knowledge the doctor needs to have, depending on the nature of the problem. In contrast, doctors usually talked about knowing as beneficial whatever the circumstances. However, all interviewees referred to the potential dangers and dis-benefits of knowing and being known and placed boundaries around it.

*Chapter Six* tackles the second research question. It discusses what importance and value personal care holds for interviewees, and in what contexts.

Interviewees generally regarded personal care as beneficent. They ascribed a wide range of benefits which are related to two main themes; the *experience* of seeking and receiving health care and the *quality* of health care in terms of *medical outcomes*. However, patients in particular also attributed varying levels of importance and value to personal care. Depending on their attendant circumstances, they considered it as essential or preferred; irrelevant or; undesirable and disadvantageous. Doctors' accounts concurred with many of these patients, but also stated that personal care enabled them to control and manage those patients deemed 'problematic' and it also provided them with occupational satisfaction. Each of these findings' chapters ends with a summary of the main points with reference to relevant literature, most of which is contained in the literature review.

*Chapter Seven* discusses more fully the three findings chapters, with reference to the literature outlined in the review and some that is newly introduced, as dictated by the findings of the analysis. First, the chapter explores how a sociological understanding can be brought to bear on the way that interviewees constructed the meaning of, and attributed importance and value to, personal care. The main sociological perspectives that have theorized the patient-doctor relationship are briefly considered, as this is the main way that interviewees constructed what personal care meant to them in this study. A post-structuralist perspective, mainly based on the later work of Foucault (1986; 1988; and as discussed by Moss, 1998), has been chosen as the best way of understanding the

complex findings of this study. The empirical work of Lupton (1996; 1997) and the theoretical work of Fox (1993; 1995) are also drawn on to this end.

Second, the chapter considers the policy and practice implications of the study, with particular reference to the NHS plans and the proposed new GP contract that are currently setting the organizational framework for the delivery of primary care services at the start of the new millennium. Thus, in this final chapter, I attempt to relate the empirical findings of this study to existing social theory in order to develop a clear conceptual understanding of them, and to apply this empirically-driven thinking to the policy and practice context of primary care.

# CHAPTER TWO

## Literature Review

*'Contemporary medicine is awash with ideas about the patient-as-person. Enablement, empowerment, negotiation and patient-centredness all form a vital part of a professional vocabulary...' (May and Mead, 1999: 76).*

### Introduction

There is a dearth of either theoretical or empirical work on personal care in General Practice as a topic of study in itself that would provide an obvious literature context for this study. The personal appears to be so foundational to the ontology of General Practice that it has rarely been problematized, more usually being treated as a taken-for-granted entity with *a priori* meaning that is axiomatic, universal and static. Thus, personal care has only an implicit presence in related areas of primary health care research.

Given this, the topic of personal care remains a rather abstract and nebulous one, and the literature for a study seeking to explore the meaning, importance and value of personal care is inevitably tangential and rather diverse. This review aims to give some coherence to this diversity. It focuses on how the personal is an underlying common thread which runs through the literature, and loosely categorizes the different ways in which it has been conceptualized.

Two bodies of work have been identified as relevant to this thesis. The first has typically been undertaken within University Departments of General Practice and predominantly has taken a policy and practice focus. It gives an insight into how the personal usually has been implicitly conceptualized. It also provides a reference point for this study's findings about the importance and value that care with a personal quality, however defined, holds for both patients and doctors. However, this body of work is inconclusive and contradictory and does not provide an adequate framework within which to understand the study data. I, therefore, have turned to a second body of work; sociological theorizing about the patient-doctor relationship. This work also gives insight to how the personal usually has been implicitly conceptualized. It is especially relevant because the patient-doctor relationship is the main way that both patients and doctors articulated what personal care means to them. I summarize the main sociological perspectives and discuss briefly how they have been critiqued. I particularly note the work of Foucault as he is one of the few thinkers to consider the concept of the personal explicitly. Indeed, several important themes that emerge from these data can usefully be explored and understood through reference to these two bodies of work.

Clearly, General Practice research and sociological work are not mutually exclusive. Sociology as a discipline is often drawn upon in health services research, and there is a constant inter-play between theoretical and policy-cum-practice focused work. But, for the purpose of writing the literature review in this thesis, the distinction is a helpful one. Cross-cutting this, I split the review



into two main categories. I start with work, both General Practice-oriented and sociological, that has *implicitly* conceptualized the personal. This is followed by discussion on atypical work from both arenas, which has examined *explicitly* the personal in General Practice as a topic of study in its own right. This has been done for heuristic reasons, and serves the further function of highlighting the paucity of research that has treated the personal as a problematic. In short, by providing an overview of how the concept of the personal has been conceptualized in both medicine and social science, this literature review attempts to critically scrutinize some of the assumptions underlying the notion of personal in care.

## **Personal Care in General Practice: Implicit Conceptualizations**

### **Conceptualizations Abound**

The concept of the personal is one that is deeply rooted in the tradition of General Practice and pervades its professional rhetoric and literature. The discourse of the personal doctor caring for the whole family from cradle to grave or, at the very least, through an episode of illness is recurrently invoked. For many medical professionals, academics and other commentators, the archetypal Dr. Findlay providing personal care to patients is the quintessential General Practitioner (Berger, 1969; Loudon *et al.*, 1998; McWhinney, 1998). It is the 'spirit', as well as the reality, of the personal doctor that is thought to be at risk of dying.

However, it is well recognized that the personal quality in care has been implicitly conceptualized in a number of different ways (Starfield, 1980; Freeman and Hjortdahl, 1997; Guthrie and Wyke, 2000). Indeed, as May and Mead, quoted above, point out:

*'Contemporary medicine is awash with ideas about the patient-as-person. Enablement, empowerment, negotiation and patient-centredness all form a vital part of a professional vocabulary...'* (May and Mead, 1999: 76).

As I demonstrate in this chapter, the concept of the personal is perhaps most notably enshrined in two main ideas; the patient-doctor relationship built over time and the interaction between patient and doctor in individual consultations. Within these, the personal has an underlying presence in work on, for instance, the 'therapeutic' patient-doctor relationship, 'continuity of care' with the same healthcare professional over time, the 'patient-centred' consultation style and the 'patient-centred clinical method'. Further, it has been a key feature in General Practice research on doctors' practice standards, where measures of quality of care have typically incorporated some notion of the personal as a proxy measure of 'good' care.

### **The Main Tenets of Thought**

The personal is characterized in the literature by some key features, notably; the doctor's commitment to the individual person, compassion for her suffering, and the patient's trust in the doctor (McCormick, 1996; Taylor, 1997; McWhinney, 1998). The emphasis in General Practice on personal, as

distinguished from technical, aspects of care has evolved as General Practice itself has developed as a profession. This development has included both its organizational structure and professional culture or identity, underpinned by a set of professionally-defined core values. General Practice has primarily adopted a bio-psychosocial approach to the practice of medicine and this is apparent in the writing of those who have most influenced the profession.

Indeed, the crystallisation of the personal at the centre of General Practice in respect of the patient, and arguably also the doctor, is enshrined most particularly in the theorization and writings of Balint in his influential work, *'The Doctor, His Patient and The Illness'* (1964). Balint's thesis assumes an essentially psycho-dynamic understanding of the practice of medicine, emphasizing the interaction between patient and doctor. Specifically, the work focuses on the individuality of the patient, the patient as whole person whose personality, concerns and social context are all relevant to the diagnosis and treatment process. It also includes the idea that the relationship between patient and doctor is in and of itself therapeutic or, as Balint himself puts it, the doctor as *'drug'*. The importance of the doctor's values in determining how the patient should behave when ill and in deciding how she should be treated is also incorporated in this thinking and, following from this, the need for doctors to be aware of their own values, attitudes and personality and the effects of these on the practice of medicine. In short, Balint emphasizes the need for the doctor to be *'reflective'* about her practice.

The research-cum-training approach of Balint's work stresses the importance of emotions both in the doctor and the patient and is concerned primarily with developing the observational and listening skills of doctors so that they are:

*'... enabled to make more sense of the interpersonal aspects of their clinical work'* (Balint, 1964: 7).

Balint stresses the importance of developing skills to help the doctor get to know the patient well and to build the relationship so that it may become therapeutic, in and of itself. The emphasis of this sort of work is on the doctor achieving a solid relationship with the patient in order to understand her as an individual and be an integrated part of the ongoing process of the treatment provided.

Balint has had a major influence on the construction of personal care as a core value of General Practice and in the working practices of GPs. In essence, the notion of the personal in General Practice has been evolving since the 1950s onwards and is now firmly entrenched. Drawing on the work of Balint, General Practice training to this day focuses on patient-doctor communication skills, consultation style and the therapeutic relationship.

Byrne and Long's study of General Practice consultations (1976) is a typical example of work that offers insight into how Balint's bio-psychosocial approach to medicine has been taken up and further integrated into General Practice thinking. Byrne and Long studied the interaction between the patient and doctor through interview and observation, and developed a typology of

consulting practice which distinguishes between '*doctor- centred*' and '*patient-centred*' styles. The doctor-centred style is characterized by focusing on the person's disease, eliciting information from the patient on clinical symptoms in order to provide a diagnosis and directing the patient to accept a particular treatment. In this style, closed questions are asked, with little opportunity for the patient to be actively involved in the consultation and, so, it is typified by the doctor's paternalism and the patient benefiting from the doctor's '*expertise*'.

The patient-centred style is characterized by a more mutualistic approach in which the doctor is less authoritarian. This practice style has an emphasis, not so much on the clinical diagnosis of disease, as on the exploration of the illness in the context of '*who*' the person is. The doctor gives the patient encouragement to participate in the consultation through a more open questioning style, and importance is attached to the patient's view of the problem. This study exemplifies how patient subjectivity and wider life context typically have been embraced as essential aspects of General Practice.

Tuckett and Boulton (1985) take the doctor- and patient- centred typologies as a construction of practice style further. They argue strongly in favour of the doctor adopting a patient-centred approach. They challenge the belief that the relationship should be characterized by the expert doctor giving the lay patient advice, which must automatically be accepted by the patient as a matter of trust due to what they call the '*competence gap*'. Instead, they emphasize that the relationship should be one based on the sharing of information, the proverbial '*meeting between experts*'. Tuckett and Boulton give five core reasons for taking

their position, and these are worth considering here as they illustrate some of the rationale which lies behind current thinking on what should characterize personal doctoring.

The first reason is the need to provide a *'reassuring'* explanatory framework; that is that the doctor needs to share information, give reassurance and understand the perspective of the patient in order to sustain a therapeutic role. This thinking refers back to a long tradition of *'healing'*, which focuses not only on the technical aspects of care but also on helping the patient deal with the experience of her illness by providing a framework within which to make sense of that experience.

The second reason draws on the process by which the patient makes her own decisions about whether or not to follow the doctor's advice and, so, they argue that the patient's compliance cannot be taken for granted. Reference is made to studies showing that large numbers of patients do not take their medication correctly or choose not to comply at all, in order to support the adoption by GPs of the patient-centred practice style. This is also witnessed in the current shift from notions of *'compliance'* to those of *'concordance'* (Mullen, 1997; Marinker, 1997).

Third, the position rests on the notion of *'multi-dimensionality and subjectivity'*; that is the patient's experience of illness, and her response to it, cannot be separated from the context of everyday life. Only when the doctor can place herself in the position of the patient and acknowledge the importance of the

person's subjective reality can the 'correct' treatment, with any hope of compliance, be achieved.

Fourth, Tuckett and Boulton reference work that has examined the decision-making process by which people choose to consult their doctor. They also consider work that examines the process by which people make sense of the consultation and decide to act on the advice given or otherwise. All of these decisions are found to occur within a social context and that of the patient's own understandings.

Last, they also point to the philosophy of '*consumerism*', which they argue resulted in an explosion of interest by the lay population in popular medicine, a focus on how to improve the patient's authority in the consulting room and a general increase in the emphasis on patients' rights as underpinning the need to move toward a shared approach in the consultation.

This work both reflects, and has contributed to, the construction of General Practice as embracing the personal, and not just the technical, in the care given to the patient. This patient-centred style has become, and remains, a widely accepted and idealized approach in General Practice. The style has been further developed and formalized into the patient-centred clinical method, a model for working practice, as typified by the work of Fehrsen and Henbest (1993) and Stewart and Brown (1995). Stewart and Brown have set out six components of this method, identified as:

1. Exploring the disease and the illness experience
2. Understanding the whole person
3. Finding common ground regarding management
4. Incorporating health promotion and prevention
5. Enhancing the doctor-patient relationship
6. Being realistic (Stewart and Brown, 1995: 100)

Research associated with this approach has focused on identifying the component parts of a patient-centred style and transforming that preferred style into a formal method of working within the consultation.

Thus, the personal in General Practice has been conceived in terms of the patient-doctor relationship built over time and the interaction between patient and doctor within each individual consultation. The profession has drawn on the wider discourse of psycho-social medicine. More generally, these foci of interest show that it has been conceptualized in terms of human subjectivity. The emphasis is on the patient-as-person, a sentient being, whose subjective understanding, experience and life context are all crucial to the medical encounter and to the provision of efficacious treatment. The patient's individual understandings, opinions and life context have become the legitimate, and indeed necessary, focus of the doctor's interest. In short, a bio-psychosocial paradigm has been drawn on and has predominated the thinking, rhetoric and practices of General Practice.



The subjectivity of the doctor also figures large in this construction of the personal. The persona of the doctor, her human qualities of compassion and empathy, her personality, her values and attitudes all feature prominently in modern General Practice medicine. The doctor's humanity and ability to understand and empathize with the patient's particular situation are characteristic of the construction of good medical care.

These features of the personal that pervade General Practice are increasingly reflected in the education and training of medical students, with the inclusion, for instance, of social science and of practice skills, such as communication with patients and their families. These have become a core part of the General Practice curriculum and are thought to be essential to the present day (RCGP, 1972; Oleson *et al.*, 2000). These personal components of care also feature prominently in the empirical work undertaken within primary care research, as I now discuss.

### **Research on the Personal as Patient-Doctor Relationship**

Empirical research, often undertaken in University Departments of General Practice, reflects the eminence of the bio-psychosocial perspective in the profession's thinking, stated core values and wider rhetoric, and the profession's pre-occupation with the interpersonal features of care, as described above.

This body of work includes research on personal care conceptualized in a number of ways. First, it has been conceptualized as the relationship with a

health care professional over time, often referred to as continuity of carer. This includes research that examines the association between continuity of care, health outcomes and expressed patient satisfaction levels and explores what patients value about this care. Second, it includes research that has conceptualized the personal in terms of the patient-doctor interaction that takes place within each consultation. This research examines associations between what happens in the consultation and outcome measures, typically using the same measures of health outcomes and expressed patient satisfaction levels. Finally, it includes research that measures quality standards in General Practice using a conceptualization of the personal as a proxy measure of quality care.

Continuity of carer is usually operationalized by the frequency and duration of the time the patient consults the same practitioner and as the extent to which the patient identifies with a particular practitioner. Some evidence of a positive association between continuity of carer and improved health outcomes has been found. For example, in relation to maternity care in the UK, Flint *et al.* (1989) found a reduction in the use of analgesia in labour when a known midwife was present, and a decrease in obstetric intervention, particularly in relation to augmentation of labour and intra-partum analgesia. This has been replicated in other countries. Hodnett *et al.* (2000), for example, in a Canadian study found that continuity of carer during pregnancy was associated with; lower antenatal hospitalization, higher attendance at ante-natal education classes, taking fewer drugs for pain relief and babies requiring less resuscitation than a control group where care was given by multiple carers. Similarly, Rowley *et al.* (1995) in

Australia found continuity of carer in maternity care was associated with fewer adverse neo-natal and maternal outcomes and with lower costs.

There is evidence from the United States of health improvements for patients with chronic conditions resulting from the patient seeing the same specialist doctor over time (Kaplan *et al.*, 1989). This study reported on four clinical trials that measured specific elements of patient-doctor communication against health outcomes in the context of carer continuity. Overall, improved health was positively associated with the patient having more control in the interaction, being given more information, and the patient saying more and being enabled to express her emotions. The study interpreted these findings as evidence that the patient-doctor relationship is a social bond that forms a part of the patient's social support network and that this leads to health improvements.

Love *et al.* (2000) also found that continuity of carer impacted positively on provider communication, the patient's level of influence over care and life satisfaction for all patients, but found the association to be strongest for those with asthma. The authors suggest that the doctor's accumulated knowledge of the patient over time allows insight to progress, more individualized treatment and the development of a therapeutic relationship and, so, the patient's trust in the physician. Similarly, there is evidence that the doctor's knowledge of the patient over time improves her ability to gauge the patient's emotions, and enables her to reveal and discuss intimate problems (Gulbrandsen *et al.*, 1997). Greater patient disclosure resulting from seeing the same practitioner was also found in relation to parents discussing their children's behavioural problems in

a US paediatric clinic (Becker *et al.*, 1974). Also, in the US, lower rates of hospitalization amongst those receiving personal continuity have been identified (Wasson *et al.*, 1984; Gill and Mainous, 1998) and a reduction in the use of emergency departments in respect of paediatrics has been associated with patients usually seeing the same attending physician (Christakis *et al.*, 1999).

Compliance with treatment has been an area of particular interest in this field and there is evidence of a positive association with continuity of carer. For example, Ettlinger and Freeman (1981) found a positive association between personal continuity and short-term compliance with antibiotics in UK General Practice. There, the degree of compliance with this drug treatment was found to be strongly associated with the patient knowing the prescribing doctor well. Also working in a UK setting, Howie *et al.* (1999) examined the association between continuity of carer with patient 'enablement' (used as a proxy outcome measure of quality of care), and concluded that this increases with carer continuity. Knowing the doctor well was the single most powerful predictor of enablement. Patients in small practices were more likely to know their doctor well and, thus, were most 'enabled'.

In one Norwegian study (Hjortdahl and Borchgrevink, 1991), the patient-doctor relationship was expressed by doctors as impacting on the use of medical resources. The personal component of care was operationalized as both the intensity and duration of the relationship with the doctor and whether the patient perceived the doctor to be her own. In recognition that frequency of contact between patient and doctor does not in itself give an indication of the

quality of the relationship, the study took account of the doctor's prior knowledge of, and sense of responsibility toward, the patient in its working definition of continuity of care. Accumulated knowledge of the patient was found to be associated with saving time in the consultation, especially for those with chronic diseases, and for children and elderly people. It was further associated with carrying out fewer laboratory tests, the doctor being prepared to make more referrals and to give sick notes, and the authors concluded that it led to more '*expectant management*'. It also marginally decreased doctors' use of prescriptions (by 5%). The study concludes that, overall, carer continuity allows for more knowledge of the patient and this facilitates the doctor to take more '*risks*' and to use a '*wait and see*' policy with known patients.

Much of the research is non-UK based and has been conducted in specialist settings. Findings cannot be easily generalised to the United Kingdom or to the particular arena of General Practice within the UK (Guthrie and Wyke, 2000). Furthermore, other studies looking at the association between continuity of carer and health outcomes found no association in relation to conditions, such as hypertension, gonorrhoea in teenagers and epilepsy (Phillips *et al.*, 1984; Chacko *et al.*, 1987; Freeman and Richards, 1994).

Freeman and Richards (1994), reviewing the evidence, declared that:

*'So far, no study has shown that patients with a chronic illness benefit from seeing the same doctor in general practice although many believe this is so'* (Freeman and Richards, 1994: 1).

From this starting point, they undertook a study that instead examined whether carer continuity was associated with epileptic patients' ability to discuss personally important aspects of their illness with the known doctor. The study found that carer continuity was not associated with their ability to talk with ease to the known doctor about psycho-social aspects of their illness. The authors conclude that it is the doctor's individual communication skills and not the contact over time that makes a difference in this respect.

In studies that have focused on satisfaction with care as the main outcome measure, there is more compelling evidence of a positive association between expressed patient satisfaction and care given over time by the same healthcare professional. Randomized controlled trials in paediatric and medical clinics in the US and Australia have found that satisfaction is higher where there is personal continuity of care (Becker *et al.*, 1974; Wasson, *et al.*, 1984; Hodnett *et al.*, 2000). Greater satisfaction was also reported by the women who experienced carer continuity in maternity services in the UK and Australia (Flint *et al.*, 1989; Rowley *et al.*, 1995).

In Norway, primary care patients who usually see the same practitioner express more satisfaction about their care (Hjortdahl and Learum, 1992). This study found that '*continuous and personal care*', defined both as the duration and intensity of relationship, are, on the whole, positively associated with increased levels of patients' expressed satisfaction levels, although this is less significant amongst those who present with a psycho-social problem. The study concludes that personal care should be seen as a component of quality care in General

Practice, not as a proxy measure of it. Such evidence of a positive association between the patient-healthcare practitioner relationship and patient satisfaction also exists in some UK studies (Baker, 1996; Baker and Streatfield, 1995). Further, continuity of carer is found to be positively associated with increased doctor satisfaction (Hjortdahl, 1992).

The Baker and Streatfield study, cited above, also concludes that patients are more likely to receive personal care, defined as continuity with a known practitioner, in smaller practices. This finding is supported by Hippisley-Cox *et al.* (2001). As indicated earlier, practice size is found to feature in the extent to which patients are known and are enabled by their doctor (Howie *et al.*, 1999).

Work that has conceptualized the personal in General Practice in terms of relationship has also examined what patients state they value about their care. One large European study of eight countries found that four of the top five priorities for patients were related to aspects of care usually associated with receiving a personal service (Grol *et al.*, 1999). These were; having a doctor who is easy to talk to, who listens, who gives full explanations and who keeps information confidential. These priorities sit alongside other, more technical, criteria, such as getting rapid access in emergencies and doctors keeping up-to-date medically.

Smith and Armstrong (1989) also compared the criteria patients emphasized as being important in General Practice care to that defined by medical and government officials. They found that the three qualities most valued by

patients were those reflecting the 'traditional' values associated with personal doctoring; having a doctor who listens, having a doctor who sorts out problems and usually seeing the same doctor. In general, all patients in the study seemed to value attributes which emphasize receiving personal care rather than the more technical aspects of care. This preference increased with age, with older people rating most highly seeing the same doctor, being recognized by staff and having a nurse available.

Other similar work has measured the extent to which care with a personal component is valued by patient groupings. Freeman and Richards (1990), in a study that focused on the impact of practice organization on the potential for continuity of care and the importance of such care by patient groupings, reported a relatively high association between personal continuity and the seriousness of a problem. Consulting rates with the same doctor increased for those with major health problems. This was found to be the case particularly for those with chronic problems, where consultation focused on ongoing management, and the need for subsequent appointments was more easily predicted.

This conclusion is supported by Al-Bashir and Armstrong (1991), when they examined the implications of financial incentives under the 1990 contract in General Practice. Personal care was found to be prioritized by patients, with this association being particularly significant for older people and those who perceived themselves to have the poorest health. Thus, whilst care with a personal component is hypothesized to be beneficial to all patients in this arena,



such work also suggests that it is of greatest import for particular patients, including older patients and those with life-threatening and chronic complaints.

It is also noteworthy that a common feature of studies in this body of work is that, for the purpose of measurement, the definition of what constitutes personal care and the criteria assembled to measure the comparative value of various aspects of care across patient groupings have usually been researcher-, rather than patient-derived. Further, the work has tended not to examine the specifics of why patients find these attributes valuable nor explore the everyday life context within which these may have importance for people.

One exception to this is an ethnographic study by Huby *et al.* (1998) on patients with HIV/AIDS in Scotland. They explored the meaning people attributed to seeing the same doctor and also the value placed on it within the context of their wider circumstances. The emphasis here was, unusually, on patients talking about their *experience* of care rather than on researcher-derived outcome measures. The study found that people wanted to see the same GP and that the relationship was valued for being familiar and ongoing. Being known by their GP was beneficial in affording patients a sense of control over their care that was lacking when attending a number of different, multi-disciplinary practitioners. It also was described as allowing them to retain a particular identity with their GP that was said not to be possible when dealing with a large number of health care professionals.

## Research on the Personal as Consultation Style

Research on consultation style implicitly embraces the concept of the personal and has focused on the doctor's behaviour within the consultation. At the heart of this work is encapsulated the idea of patient-centredness. It is important for this thesis because it demonstrates how the personal typically has been conceptualized as relating to the doctor's orientation, style and communication skills within the consultation, and not only as that which occurs in the relationship built over time. However, patient-centredness has been defined and operationalized in a variety of different ways (Byrne and Long, 1976; McWhinney, 1989; Winefield *et al.*, 1996).

Stewart (1995) carried out a meta-analysis of the association of patient-centredness as a consulting style and health improvements. She found that most studies had operationalized patient-centredness in terms of the doctor's communication skills and orientation, emphasizing an '*egalitarian*', power sharing style. Outcome measures included; the status of patients' emotional health, symptom resolution, overall functioning, and physiologic measures such as blood pressure, blood sugar and pain control. Of the twenty-one studies she reviewed, sixteen showed evidence of a positive association, four reported non-significant results and one was inconclusive. Stewart suggests that these positive results are explained by:

*'... the provision of a caring, respectful and empowering context... a shared, egalitarian process'* (Stewart, 1995: 1431-2).

This conclusion is supported by Verhaak (1988) who found that the doctor taking a patient-centred approach in the consultation created an atmosphere that allows patients to more easily raise and discuss personal issues.

Further, Grol *et al.* (1990) measured doctors' consultation style, categorized as doctor- and disease-centred or as patient-centred, against health outcomes in Belgium and the Netherlands. They conclude that a patient-centred style is positively associated with a reduction in prescribing rates, more adequate psycho-social care and practice routines, and better interpersonal performance. However, significant differences between the findings in the two countries led the authors to warn against ignoring the social and cultural contexts of these conceptualizations and of making the assumption that patient-centredness is inherently positive and, so, an adequate marker for quality of care.

To illustrate the focus of this type of research and the uncertain nature of the findings, Henbest and Stewart (1990) hypothesized that patient-centredness as a practice style was associated with improved outcomes and sought to examine the process by which this style positively impacted on patient care. The orientation of the doctor's style was measured against six outcomes. These were: the doctor being able to ascertain all the patient's reasons for consulting; the doctor and patient reaching an agreement about the nature of the problem; the patient feeling understood; patient satisfaction; improvement in the patient's main symptom; and reduction in the patient's concern about the main symptom. The concept of patient-centredness was operationalized by defining it as care in which the doctor's responses facilitated the patient to express their concerns,

feelings, symptoms and expectations, and this was scored on the basis of how often and to what extent open questions were used.

Although the study concludes that '*patient-centredness really does make a difference*' (Henbest and Stewart, 1990: 32), the results show that in only two of the six hypotheses; ascertaining the patient's reasons for coming and resolution of the patient's concerns, was any statistically significant association found. No association was found in relation to patient agreement with assessment or with patient satisfaction, and no statistically significant association was found with the patient feeling understood or with symptom resolution. Outcome measures decreased when the patient-centred scores were rated as intermediate.

The authors suggest that the relatively small number of patient-centred consultations in the sample may explain these unexpected results. They also propose they may be an effect of the measurement of patient-centredness by scoring the use of open questions rather than by assessing the facilitative role of the responses in context. Finally, they suggest that this may be explained by the need to see patient-centredness as a skill which requires to be practised, part of a package of care and of a more general approach in which the doctor allows the development of a relationship over time through continuity of care; that is within the context of a greater whole.

Typically, studies have operationalized the concept of patient-centredness in similar ways to Henbest and Stewart, focusing on the doctor's communication skills and the extent to which the patient is involved in general discussion and

in making treatment decisions. Stewart and Brown's study (1995) on the effect of patient-centred care on health outcomes produced equally unexpected results; they found no association with any health outcomes measured. Similarly, a study by Kinmonth *et al.* (1998), using a randomised control trial, examined the impact of patient-centred care in General Practice on patients with diabetes. The authors conclude that whilst patient satisfaction, communication with the doctor and the patient's overall sense of well-being were reported to be higher amongst those exposed to this practice style, measures of clinical improvement in the patient in terms of body mass index and triglyceride concentrations were worse than those in the control group. The intervention group was also found to have poorer knowledge scores than the control group and no significant effect was detected in relation to lifestyle or glycaemic control. Similarly, in a study by Kinnersley *et al.* (1999), a positive association was found in only one of the six areas tested; between patient-centredness and patient satisfaction.

Indeed, as some of the above studies show, there is evidence of greater expressed patient satisfaction in consultations that take a patient-centred approach. However, this is also not a universal finding. Whilst there is some evidence that patient satisfaction is improved for those exposed to a more patient-centred style of approach, a study by Savage and Armstrong (1990) found the opposite. This study compared the effect of directive and sharing styles of approach by the doctor in the consultation against patients' expressed levels of satisfaction. They found that satisfaction levels were significantly higher amongst those who were given a more directive style. This significance

increased for those with a physical problem and those who received a prescription. Similarly, a study by Winefield *et al.* (1996) found little relationship between patient satisfaction and patient-centredness. Indeed, summarising the status of this body of work, the authors note that:

*'While patient-centredness in medical consultations has often been advocated, there are no standard measures for it and relatively little empirical evidence for its beneficial effects'* (Winefield *et al.*, 1996: 811).

As with the patient-doctor relationship research, there is a paucity of work that has explored patients' views of the patient-centred approach in the consultation. Stewart herself comments that her Medline search for the terms 'patient centred approach' and 'patient centredness' in 1995 showed that:

*'Most educators and researchers focused solely on experts' ratings of observed behaviour in clinical encounters... [Inclusion] of patients' perceptions... can be described as the ultimate patient-centred finding...'* (Stewart, 2001: 444).

In addition, as with relationship research, the benefit to patients in terms of medical outcomes of a patient-centred consultation style remains somewhat inconclusive. Indeed, for those committed to the ethos of patient-centredness in primary care consultations, the empirical work has been, to say the least, 'disappointing' (Howie *et al.*, 2002).

One study that did seek patients' views (Little *et al.*, 2001) found that patients in primary care strongly valued an approach in the consultation that is patient-

centred in terms of there being good communication, a sense of partnership and health promotion. However, the study has been criticized for its methodological approach. Skelton, for instance, reasons that, if patients were asked questions, such as whether they want the doctor to understand their main reason for coming or want the doctor to be friendly and approachable, it would be perverse for them to reply in the negative (Skelton, 2001).

The personal also features in research on the development of measures of quality in primary care. Doctors' practice standards are assessed against the extent to which they show a patient-centred orientation, indicating that the personal is often assumed to be inherently positive. A useful review of the empirical literature of this area by Mead and Bower (2000 b) identifies two main methodological approaches adopted in an endeavour to measure this concept alongside clinical performance, as part of a fuller assessment of quality care. They conclude that most of this research belongs to two distinct categories.

These are, first, self-report measures of the doctor's patient-centredness. For instance, Grol *et al.* (1990) on the values and attitudes of the doctor, Balint (1964) on the doctor's personality type, and Howie *et al.* (1992) that examined process indicators of patient-centredness. Second, studies using external observation methods. For instance, the use of rating scales to measure the doctor's behaviour (Verhaak, 1988), and verbal coding schemes that sought to measure the extent to which the doctor is patient-centred (Cecil and Killeen, 1997).

To exemplify the use of an implicit conceptualization of the personal in this body of empirical research, the work of Howie *et al.*, (1991 and 1992) took patient-centredness as a proxy measure of quality care and examined its association with consultation length. The work concludes that a patient-centred style, defined as the doctor dealing with psycho-social problems, long-term health problems and health promotion, is more common in those doctors that take longer in each consultation (although this was not found to hold statistically for other patient-centred items, such as communication and mutuality). Longer consultations were also found to be more satisfying by patients. Consultation length, then, was recommended as a further proxy measure of quality in General Practice. Later work by the Howie team developed the concept of patient 'enablement' in the Patient Enablement Instrument (PEI) as a proxy measure of patient-centredness and, so, the quality standards of practice (Howie *et al.*, 1999). They conclude that enablement is positively associated with longer consultations, knowing the doctor well and smaller practices.

Thus, like work on the patient-doctor relationship, definitions of what constitutes the personal in care, and what comparative value it may have for patients against competing priorities, has been derived from researchers rather than patients themselves. Further, as Henbest and Stewart (1990) point out above, the details of or contexts within which personal care is valued by patients have not been explored. In short, this research has often been de-contextualised from patients' wider circumstances, such as the overall quality of the relationship with the doctor and the circumstances of their everyday lives.



## **Personal Care in Sociology: Implicit Conceptualizations**

In sociology, as with General Practice-oriented work, the personal is evident as a conceptualization in theoretical and empirical work on the patient-doctor relationship and their interaction in the consultation, and a weighty body of important work in this field has been produced. Indeed, all the major sociological perspectives from the 1950s onwards have theorized the role of medicine in society and, in particular, this dyad with its implicit embrace of the personal. I now consider each of these in turn, starting with the social structuralist and symbolic interactionist perspectives. I then consider the post-structuralist approach of Foucault, who has challenged the unproblematic way the patient-as-person has been dealt with in these earlier writings. In this section of the review, I draw heavily on the writings of Annandale (1998) and Bury (1997).

### **Consensus Perspective: Structural Functionalism**

The consensus model of structural functionalism is most associated with the work of Talcott Parsons. Parsons is noted as being one of the first sociologists to theorize ill-health as a social phenomenon and not as an entity that, in itself, is the property of the individual experiencing the sickness. The work of Parsons is credited with providing the first challenge to the dominance of the bio-medical approach to health and illness. His consensus model of society considered for the first time health and illness at the macro level as well as the micro. Indeed, his work relates ill-health to the functioning of society as a whole and was part

of his overall thesis that reconciled how inequality and power differentials in social relationships could contribute to the functioning of modern society. Put briefly, Parsons viewed health as:

*'... a valued social commodity, an essential resource for individual achievement and the smooth running of society'*  
(Annandale, 1998: 10).

Arguably, the two main, and inter-related, concepts to emerge from this theoretical work, and that continue to have common currency, are the 'sick role' and the notion of illness as deviance. The sick role refers to that which the ill person adopts, consciously or unconsciously, when in need of convalescence from the stresses of meeting the everyday obligations and responsibilities of other social roles, such as parenthood or being a spouse. He imputes the need to be sick as psychological in origin. This leads Parsons to regard sickness, and the concomitant withdrawal by the patient from her 'proper' roles, as partially and conditionally legitimated. He also regards as essential the patient undertaking a therapeutic process in order to aid recovery so that she may re-adopt these 'rightful' roles. Attributing a psychological origin to the sick role means that Parsons did not seek to understand, in sociological terms, why an individual or group of people might be ill. It is the withdrawal of the sick person into the sick role, and the parallel abandonment of their rightful social obligations, that give rise to the notion of sickness as deviance, albeit partially legitimated.

The implications for the way the patient-doctor relationship has been conceptualized within this model are manifold. The patient is regarded as a

passive recipient of health care, who has an obligation to seek care from the doctor in order to regain a sufficient state of health to resume her appropriate social roles. This requires the patient to fully co-operate with the medical practitioner, to be open to the doctor's examination and questioning, and to comply with any advice given. In turn, the doctor is given the authority to question the patient, has the right of access to her body, and has an obligation to gain the patient's trust and to act with beneficence in her interests. In short, trust and consensus are defining features of the patient-doctor relationship in Parsonian theorizing.

It has been argued that this theoretical formulation of the patient-doctor relationship has been important in highlighting how medicine, with its system of rewards and sanctions, acts as a form of social control (Annandale, 1998: 10). However, a number of criticisms may be levelled at this perspective. First, functionalism does not acknowledge that the patient-doctor relationship can be characterized by conflict. Also, whilst this theorizing allows *both* patient and doctor to have rights and obligations towards one another, in the interests of society as a whole, it nevertheless sanctions and supports the structural and asymmetrical power imbalance of the doctor over the patient in the relationship.

Further, the patient is constructed as passive, the doctor as active. The patient is, albeit unwittingly, a potential deviant and the doctor acts as surveyor and manager of that deviance on society's behalf. The patient should trust the doctor, whilst the doctor is imbued with expert status that should be trusted. The patient must co-operate with the doctor and comply with prescribed

treatment without question and the doctor has the right to dictate what is in the patient's best interests. This perspective also does not take account of the fact that people's entry into the sick role operates in a cultural context, that ill-health is not morally neutral, and that the sick role cannot pertain to chronic illness (Annandale, 1998: 11). This work, arguably, has served to bolster the power base of medicine both at a social level and between patient and doctor at the level of the individual interaction. It does not challenge the structural power of medicine, nor does it raise the question of the health inequalities that arise from structural differentiation. Finally, by taking it as read that this is the 'correct' context within which the interests of both society and the individual should be served, the approach does not problematize and, so, examine the personal implicit within the patient-doctor relationship as a socially constructed concept.

This essentially positive view of medicine has not been shared by most sociological theorists and empiricists since this time. During the 1960s and 1970s there arose a direct challenge to functionalism from conflict theorists, and this body of work has come to be known as the 'medicalization critique'. A deluge of writing has been produced that regards medicine as an essentially negative force in society and the patient-doctor relationship as a site, not of beneficence, but of harm to the patient. The medicalization critique developed initially from Marxism and from the liberal humanism that underpinned emerging social movements of the era. I now outline briefly the political economy and feminist perspectives that adopted this critique, showing their criticisms of medicine as a negative force in modern society.

## Conflict Perspective: Political Economy and Feminism

Freidson was a major proponent of the medicalization critique. He challenged Parson's view that the patient-doctor relationship is characterized by trust and consensus. Drawing on the social constructionist work of Berger and Luckman (1967), Freidson argues that patients and doctors hold differing world-views that ultimately produce conflict in the relationship, be it tacit or overt (Freidson, 1970: 198). He contends the patient's distinctive social and cultural reality results in them:

*'... experiencing illness, whilst those of the doctor produce a view of the patient with disease. In this way, given the viewpoints of the two worlds, lay and professional, in interaction, they can never be wholly synonymous. And they are always, if only latently, in conflict' (Freidson, 1970: 321).*

With particular reference to the patient-doctor relationship in General Practice, Freidson also suggests that, within the context of these disparate world views, the doctor's reality is privileged, whilst that of the patient is largely ignored:

*'The routine of practice not only makes varied elements of experience equivalent-it also makes them **ordinary**. This seems to be the case especially in general medical practice... And insofar as they are considered ordinary it is not legitimate for the patient to make a great fuss about the suffering they involve. His subjectively real pain is given little attention or sympathy because it is too ordinary to worry about' (Freidson, 1970: 211, emphasis in the original).*

Freidson also contends that medicine is *'sometimes merely harmless without contributing anything to cure, sometimes downright dangerous'*, and contemporary

knowledge may be well-intentioned, but unwittingly can be *'misdirected or false and some of the patient's complaints [are] wrongly ignored'* (Freidson, 1970: 210).

This, he argues, inevitably produces conflict between patient and doctor. The iatrogenic effect of modern medicine is also a theme picked up by Illich (1975). He contends that, rather than improving people's health, medicine is damaging to people both by reducing control over their own health care and due to the side effects of modern medical treatments.

Zola (1972) was also at the forefront of the medicalization critique. He contends that medical power leads to *'medical imperialism'* through the medicalization of everyday life. By medicalization, he means an expansion of what is subsumed by medicine as relevant to its scope, in part, through public health's emphasis on *'the good practice of life'* (Zola, 1972: 496). Indeed, he asserts that social control by medicine was occurring through:

*'... a largely insidious and often undramatic phenomenon accomplished by 'medicalizing' much of daily living, by making medicine and the labels of 'healthy' and 'ill' relevant to an ever increasing part of existence'* (Zola, 1972: 487).

In addition, political economy theorists challenge the assumption that the asymmetrical power of the doctor in the relationship with the patient is morally 'correct' and socially functional. They also make a central tenet of their thesis that illness and, more particularly, health inequalities are socially produced. Thus, unlike functionalism, there is a deep concern with the origins of ill-health at a social level.

This perspective also theorizes that capitalism creates a system in which the pursuit of profit and the achievement of a good state of health within the populace are incompatible (Doyal and Pennell, 1979). Medicine is thought to be one mechanism by which capitalism is sustained. The doctor is not the master but is utilised by capital to serve its ends. However, medicine is also conceptualized as having reserved for itself a position of dominance within the established order that is self-serving. Thus, medicine is viewed as being enmeshed in the preservation and functioning of the capitalist state, and ill-health and health care are seen to be tightly bound to capital, which infuses all areas of life.

In this context, conflict and not consensus is the inevitable defining characteristic of the patient-doctor relationship. This is mirrored in empirical work, which has found that doctors do not always exhibit a well-intentioned attitude towards patients that is neutral and therapeutic, as Parsons proposes. Stimson (1976), for instance, discovered that doctors differentiated between those patients whom they liked and disliked. They also labelled some patients, notably women, mothers, and those with psychological illnesses, as 'troublesome'. Likewise, Bloor and Horobin (1975) found that doctors were dissatisfied with patients' behaviour and complained, for instance, about the high level of unnecessary night calls. They also found evidence of conflict between patients and doctors in the consultation and conclude that:

*'... the viewing of reciprocity between doctors and patients as problematic and as something which may need to be 'worked at' by both parties if overt conflict or at least covert dissatisfaction is not to occur, will increase our understanding of the*

*behaviour of doctor and patients'* (Bloor and Horobin, 1975: 271-2).

Indeed, a conflict rather than a consensus model of the patient-doctor relationship, as Bury notes, '*... appeared to have much to commend it*' (Bury, 1997: 89).

From the conflict perspective, the patient-doctor relationship is clearly not regarded as a positive force in society or as beneficent to the patient. It is regarded as the means by which capital is preserved and social class divisions and inequalities are sustained. The patient-doctor relationship is a site of conflict in which the patient is relatively powerless. Such criticisms of functionalism and the predominantly negative view of medicine have been embraced equally by feminism.

Notwithstanding long-running debates about whether the work of feminists can accurately be discussed as a single approach, given the diversity of thinking that has developed from this perspective (Doyal, 1995; Lupton, 1994), a number of significant, key features can be identified as emerging from this body of work that relate to theorizing on medicine in general and the patient-doctor relationship in particular. Regardless of the 'category' of feminist thinking work may be related to, all agree medicine is one mechanism by which patriarchy is sustained and through which it operates to oppress women. Equally, all agree on the need to overthrow this oppression, although there is some disagreement on the way this best may be achieved. There is also consensus that women's oppression is maintained through the:



*'... elision of sex and gender, attributing negatively valued characteristics to the female body and, therefore, to the female gender' (Annandale, 1998: 78).*

Medicine is centrally implicated in this construction of, and control over, women's bodies.

Empirical work within the feminist perspective focuses on analyzing male domination in the medical encounter. This has been undertaken, in particular, within the context of obstetric and maternity care. Oakley, for instance, argues that the medicalization of maternity care has propagated male dominance over women's bodies and reduced their choice of care by viewing any alternative to the male, imposed norm as *'deviant and esoteric'* (Oakley, 1980; See also Ehrenreich and English, 1974; Porter, 1990).

Such work on the patient-doctor relationship has also, significantly for the purposes of this thesis, been carried out within the context of General Practice. To exemplify this type of work, Barrett and Roberts (1978) examined the consulting patterns of middle class women and considered the way doctors recurrently attributed their, so-called, psychosomatic complaints to the boredom of their lives. However, in many such consultations, instead of challenging the family and social constraints of the woman's life, the GP:

*'... smoothes away the surface anxiety and adjusts the woman to the limitations of a life located totally in a home from which the children have moved away' (Barrett and Roberts, 1978: 42).*

They also found that GPs treated women in ways that are stereotypical; that is, as reflecting dominant assumptions about the 'essential' nature and role of women in contemporary society. They conclude that, in this way, traditional social roles were reproduced in the patient-doctor encounter and this serves to bolster established social relationships more generally:

*'In this respect the institution of medicine legitimates and endorses the status quo in relation to the position of women, and in so doing fulfils an ideological function as an agency of social control'* (Barrett and Roberts, 1978: 42).

Indeed, commonly, feminism is critical of the patient-doctor interaction and relationship, regarding these as harmful rather than potentially beneficial to patients.

Thus, feminism shares with political economy a predominantly negative view of medicine's role in modern society and emphasizes the oppressive and harmful effect of the patient-doctor relationship on patients, particularly women.

However, like functionalism, neither of these perspectives has problematized the patient-doctor relationship and explored the personal underlying it as a socially constructed concept. A further criticism levelled at this perspective is that its focus on macro, structural issues fails to take account of the interaction between patient and doctor at the micro level. The symbolic interactionist perspective, on the other hand, places its focus on just that area, and it is to this that I now turn.

## Symbolic Interactionism

Symbolic interactionism as a perspective developed during the 1960s and 1970s but, as Annandale points out, it draws on the much earlier work of Mead (1934) and Blumer (1969). It also presents a challenge to the consensus perspective of functionalism, arguing that the patient-doctor relationship is characterized by potential conflicts. It concurs with political economy and feminist approaches that the patient is constrained by a structurally and organizationally differentiated power context. It departs from them, however, by arguing that patients have some room to manoeuvre within this and to show agency in managing their health care and when interacting with the doctor.

As their starting point, interactionists assume that, although we are biological entities and biology underpins our experience, selves are also social products that emerge from interaction with others. Given this, it is axiomatic that the self is not a fixed entity but is socially emergent, shifting and variable. The self, then, is produced through reflective shaping in interaction with the environment. This reflective capacity makes people 'social actors', who are active agents in their dealings with the social world. It allows people to place interpretation upon their social activities but, as this takes place in relation to others, meaning-making occurs within certain constraints. In consequence, this approach purports that people are required to be '*artful*' in their everyday lives by negotiating meaning and by paying attention to the presentation and management of their identity (Fine, 1993: 64).

Goffman developed such thinking, and in a number of seminal works (1961; 1972) explored the dialectic of what occurs between people when they are in one another's presence in each encounter. However, he is not concerned with these behaviours as attributes of the individual but of the social order. In *the Presentation of Self in Everyday Life* (1972), for instance, Goffman theorized about people's everyday behaviour in terms of '*techniques of impression management*'. He outlines the techniques employed to maintain such an impression and likens this social work to a stage performance. Goffman puts it like this:

*'... when an individual appears before others he will have many motives for trying to control the impression they receive of the situation. This report is concerned with some of the common techniques that persons employ to sustain such impressions and with some of the common contingencies associated with the employment of these techniques... The issues dealt with by stage-craft and stage management are sometimes trivial but they are quite general; they seem to occur everywhere in social life, providing a clear-cut dimension for sociological analysis'* (Goffman, 1972: 26).

Annandale notes that Goffman's concern with the rituals and performances of everyday life was applied to the health field by Strong (1979), who studied the micro detail of interaction within the context of a paediatric clinic. Indeed, Strong provides an example of empirical work using this approach that highlights the key elements of interactionist thinking in relation to the patient-doctor dyad. He states that:

*'My concern is with ceremonies: with the social form of the occasion and the sorts of identity tacitly claimed by each party and conferred upon the other'* (Strong, 1979: ix).

Strong concludes that both patients and doctors work hard in the encounter to present themselves in a specific way and also to preserve the '*ceremonial order*' of that interaction. However, he also argues that, within this, doctors use strategies to manipulate the patient and guide them in a particular direction. Likewise, patients can disrupt the order through, for instance, insistent questioning, although the extent of this is curtailed by power differentials. This study presents evidence that both patients and doctors are active in the negotiation and management of their encounters in order to preserve its functionality. They were found to pay attention to the way in which their identity is constructed and presented. It also suggests that, within these encounters, each party makes great efforts to achieve certain ends. Strong identifies the work being done by both parties in these medical encounters as a technique or '*mode*', a way of being a patient or a doctor, which he calls the '*bureaucratic format*'.

Other examples of empirical work in the health field that have drawn upon this approach include Stimson and Webb's study, *Going to See the Doctor* (1975). They showed how patients and doctors presented themselves in a particular way and employ tactics, such as negotiation, again in an attempt to achieve their own ends in the interaction. Similarly, Silverman's *Communication and Medical Practice* (1987) found that, with the passage of time, parents of diabetic children took an increasingly active and challenging role in their interaction with the doctor.

Clearly, this emphasis on the socially constructed nature of the self and the focus on the minutiae of the interaction between patient and doctor are distinctive from structuralist approaches. Patients are perceived as social actors who have agency, albeit this agency must operate within the constraints of existing power relationships and organizational or structural parameters. However, akin to others who subscribe to the medicalization critique, interactionism regards the patient-doctor relationship as a site of potential conflict, and one which does not always produce beneficial results for patients. To this extent, it shares a pessimistic view of the place of medicine in the modern world and of the potentially problematic and harmful nature of the patient-doctor relationship.

Interactionism has many strengths. It allows an exploration of the practical elements of the patient-doctor relationship. The position of both parties are given credence and taken seriously, and lay people are presented as experts on their own lives. Through such an analysis, the world which constrains and enables the practice of good primary care can emerge from practical examples and not abstract philosophy. However, it can be criticized for offering little or no analysis of power or inequality and how such power is played out in the primary care setting. It also has not explored the personal which is embraced implicitly in the patient-doctor relationship as a socially constructed concept.

Whilst each of the above perspectives advances a different theoretical understanding of the role of medicine in society and the patient-doctor relationship/interaction, in particular, they all tend to examine the patient-

doctor configuration in order to theorize more widely about issues of concern in social life, such as power and authority. As Bury states:

*'... interactions and relationships in health care have been of theoretical interest to sociologists, partly because they illustrate some of the major features of modern society. The position of doctors and patients exemplifies, in particular, the central place of professional authority and its acceptance or resistance by people who encounter it. The doctor-patient relationship is not only a major aspect of modern health care experience but also is a critical lens through which the impact of scientific, technical and rational authority on everyday life can be observed' (Bury, 1997: 79).*

Indeed, researchers have all done so rather than explicitly exploring the patient-doctor relationship and interaction and, thus, the concept of the personal that underlies these. However, the theoretical work of Foucault, and those who follow him, is major exceptions to this, and it is to this perspective I now turn.

## **Personal Care: Explicit Conceptualizations**

### **The Perspective of Foucault**

Foucault provides an important contribution to thinking on the role of medicine in society. He traces the development of bio-psychosocial medicine that has at its very heart the concept of patient-as-person, and seeks to explain its predominance in the modern age. Like modernist sociological perspectives, he examines the social function of medicine, and an analysis of power is also central to his thesis. However, his approach is distinguished by treating the

personal as a concept that is time and space specific, by tracing its historical and social origins and, therefore, by treating it as problematic.

Foucault's analysis is contained mainly in his writings *Discipline and Punish* (1979) and *Birth of the Clinic* (1973). These works argue that clinical examination emerged at the end of the eighteenth century when the mechanisms of power in European society underwent a profound change. It purports that the sovereign power of the old regime was inscribed on the body of the king's subjects and that power, and the social order it created, was wielded and maintained in public and ritualistic ways. The passing of the old regime resulted in '*an inversion of visibility*', meaning that the emerging new regime relied on the more private and hidden exercise of discipline and punishment of the body. Thus, new strategies of power were targeted primarily at the human body and, so, *disciplinary* power operates through the governance and regulation of the body.

This theory of power makes a striking contrast with other critiques, which theorize power as an entity held by elite social groups, as imposed from above, and as exercised in overt, coercive and, sometimes, violent ways. For Foucault, power is omnipresent, suffusing all areas of life and can be both a dominating and productive force. The identity of the patient as having subjectivity, constructed as an individual person, was both the object of power (dominating) and, through its construction, the effect of power (productive).

Surveillance is the underlying mechanism of this disciplinary power.

Education, psychiatry, social work, law and penology sit alongside medicine as



the *disciplines* that are important sites of surveillance. Medicine exercises disciplinary power through the instrument of the clinical examination of the patient's body. *Le regard* or the 'medical gaze' on the patient's body has made it the subject of constant surveillance.

No longer constructed as a passive, bodily receptacle for disease, Foucault suggests that the patient has been reconstituted as having a subjective reality. The patient has become a 'case', the unit of medical observation and treatment, and the individual, or patient-as-person, has emerged in Western medicine. At this micro level, the patient-doctor relationship is a site of *disciplinary* power. This, combined with the macro-level surveillance of populations through public health medicine and its particular emphasis on 'lifestyle', constitutes Foucault's notion of *governmentality*. In his later work (1986; 1988), this was developed further and his interest came to lie in the idea of the practices of the self; of self-care, self-surveillance and self-confessing.

Armstrong develops Foucault's critique and applies it specifically to the patient-doctor relationship in General Practice (1979; 1982; 1984). The advent of bio-psychosocial medicine as an historical artefact is traced but, rather than regarding it as the manifestation of humanistic enlightenment, he uses Foucault's thesis to contend this paradigm has produced the patient as a subjective being with the effect of exercising *disciplinary* power. Indeed, he argues that General Practice's adoption of the bio-psychosocial discourse of medicine makes both the consultation and relationship particular sites of surveillance and, so, instruments of that power in medicine. He traces the

genealogy of the development of the patient-as-person, whose perspective should be central to the medical encounter, and, thus, locates his analysis firmly within a wider historical and social context. By so doing, he offers an explanation of how the personal has come to take such prominence within the realm of General Practice in particular.

In this analysis of the reconstitution of the medical gaze, he highlights a move away from the construction of medicine as a purely technical exercise towards the incorporation of the personal in the mid-twentieth century. He cites the Goodenough Committee Report of 1944 on Medical Education, which emphasizes the importance of teaching students exclusively about the clinical diagnosis of disease. He argues that this reflects the dominant view of the time: that the patient was a *'passive object in which was contained interesting pathology'* (Armstrong, 1982: 109), and the doctor was a clinician who should be solely concerned with accurately recognizing and treating disease. Armstrong compares this view of the patient to that contained in the Todd report of 1968. Produced by the Royal Commission on Medical Education, he notes that the report emphasizes the importance of taking account of the patient as a person in coming to a clinical diagnosis. In relation to *'taking a history'*, the report points out that:

*'... there is a great deal more to this than simply asking a series of prescribed questions. Students must be aware of the factors, which impede or distort communication, factors such as limitations of vocabulary, cultural attitudes and social prejudices'* (Armstrong, 1982: 109).

Thus, Armstrong argues, within a short period of time, the patient moved from being seen as a passive receptacle for disease to become a more whole, sentient being whose personality and wider context featured within the medical paradigm. Notions of whole person, the idiosyncratic patient, knowledge of individuality and subjectivity came to the fore. Within this construction, the patient's view has become central to the consultation and ongoing relationship with the GP. Delineating the genealogy of this development in General Practice, Armstrong notes:

*'The patient's view was no longer a vicarious gaze to the silent pathology within the body but the precise technique by which the new space of disease could be established: illness was being transformed from what was seen to what was heard (Armstrong, 1984: 739).*

This construction of patient-as-person incorporating these features is evident in the thinking, rhetoric and empirical work in General Practice outlined in the early section of this review.

Indeed, Armstrong places this shift in the middle of the twentieth century towards the construction of the personal in medicine within a wider historical and social context. He situates the seminal work of Balint (1964), discussed earlier, in this context and as offering further evidence of this shift. He argues that Balint reflected and brought into focus the more general shift within medicine towards a new discourse that incorporated the notion of the personal in General Practice medicine. Armstrong contends this had the effect of reconstituting the patient as a sentient being and placed the personal at the

centre of the patient-doctor configuration. Along with this reconstitution of the patient-as-person under the medical gaze of the clinician came the appearance of the problematic patient-doctor relationship. He asserts that the patient-doctor configuration became a central construction in the discourse of modern General Practice medicine.

Armstrong takes Foucault's line that this development within medicine was part of a much wider social transformation from *sovereign* to *disciplinary* power. He notes that these developments within the medical profession have been mirrored in the social sciences where, in parallel with medicine's construction of the patient as an individual and idiosyncratic being, the patient also became the subject of '*observation, description and analysis*' (Armstrong, 1982: 117). Indeed, as I will discuss further in the methodology chapter, this thesis, concerned as it is with the patient's view, is considered both to reflect and be a product of that development.

He and others promote Foucault's thesis that such a development in medicine was mirrored in the adoption by allied professions such as nursing, psychiatry and social work. He argues that the discourse of the personal, of the patient/client as person, became pivotal to the working ethos and practices of much of the twentieth century welfare state (Armstrong, 1982; 1984; 1987; May *et al.*, 1996; May and Mead, 1999). May, for example, refers to this as '*the interpersonal economy of professional relationships*' that developed in the post-war period across many disciplines, making the patient's '*interiority*' the focus for medical and allied work and for empirical research in General Practice (May *et*

*al.*,1996: 190). It is in this context, then, that the patient-doctor relationship and interaction have become the long-standing foci of interest which typify theorization and research in General Practice.

Armstrong further argues that when the patient became reconstituted as person, and the problematic patient-doctor relationship came into view, so did the subjectivity of the doctor. The doctor also became a sentient being and her personal qualities figured large in the construction of medicine, and in General Practice in particular (Armstrong, 1984; Gothill and Armstrong, 1999). This contention is strengthened by the rash of empirical research and commentary that focuses, for example, on stress in General Practitioners (Howie *et al.*, 1991 and 1992; Huby *et al.*, 2002) and their views and experience of care-giving (Calnan, 1988; Fairhurst and May, 1995 and 2001; Lupton, 1997). Indeed, such work constructs doctors, like patients, as experiencing human beings. By so doing, the 'problem' of the patient-doctor relationship and of the doctor's lack of or inadequate consulting skills have come into view and become a focus of much empirical research (Armstrong, 1982; May and Mead, 1999).

Though not making a claim taking a Foucauldian perspective, Jewson (1976) provides a similar, though not identical, historical and social explanation as Armstrong does for the focus on the personal in General Practice. He argues that the concept of the patient-as-person previously existed within the medical paradigm, or what he refers to as '*medical cosmology*', and began to disappear during the late eighteenth century with changes both in the structure of social relations and the means of production of medical knowledge. In short, he

argues that *'bedside medicine'* predominated until this period. The cosmology of bedside medicine is typified as: Seeing the patient as a whole person, as having a *'conscious human totality'*, with no distinction being drawn between the psyche and the soma; treatment based on the patient's self report of the disease's external manifestations and of their own subjective experience of that disease; and as the opportunity for the patient, in the context of an equitable relationship with the doctor (because doctors' income depended on their well-off clientele) to contribute to, and negotiate about, the nature of the illness and the treatment to be used.

Jewson argues the disappearance of the patient-as-person, or what he refers to as the *'sick-man'*, occurred with the emergence of first hospital-, and then laboratory-based medicine. These two cosmologies are described within his thesis as being more concerned with underlying causes of disease, rather than their surface appearances, and with the patient's subjective expression of feelings and sensations, thus reducing the sick-man to *'a collection of synchronised organs, each with a specialised function'* (Jewson, 1976: 229). Judgements about diagnosis and treatment no longer are constructed around notions of the patient as an idiosyncratic individual, but are determined by a system of beliefs which standardizes and circumscribes the construction of the disease and, so, categorizes the patient as object. Jewson summarises the distinction between these different medical cosmologies:

*'The study of medicine is focused upon the recurrent, objective, quantitative characteristics of categories of the sick rather than upon the unique, subjective, qualitative differences between individuals. The universe of medical discourse is seen to be*

*composed of inanimate objects. Living organisms and their ailments are conceptualized as law-like combinations of non-living elements and substances, life and death as physico-chemical processes. The study of life is replaced by the study of organic matter'* (Jewson, 1976: 232).

Thus, the emergence of the patient-as-person in General Practice medical discourse, reflected in the Todd Report of 1968, and identified by Armstrong as bio-psychosocial medicine, which reconstituted the patient under the medical gaze, may indicate the re-appearance, rather than the birth, of the personal within contemporary medicine. However, the emergence of the patient as a sentient being whose subjective reality is of importance, within the configuration of the patient-doctor relationship, is not disputed within this paradigm and is clearly evident in the current discourse of medicine, as this review of the literature shows.

Also adopting a Foucauldian perspective of power relations on the patient-doctor relationship, Osborne (1994) asserts that ethical stylizations of *expertise*, such as treating the patient-as-person, are central to the exercise of *disciplinary* power in medicine. He draws on the work of Armstrong, supporting his contention that the patient-doctor relationship emerged as a central feature of General Practice medicine during the twentieth century. He notes that during the 1960s and 1970s the Royal College of General Practitioners made central to the profession's ethical base and working practices the concept of the personal and offers an explanation about why it has become particularly prominent within General Practice. Osborne argues this was a period in which the

'renaissance' of General Practice occurred and that enhancement of this area of medicine was supported by:

*'... the invention of a particular diagram of functions for defining the nature of General Practice as a vocation, that is by the adoption of 'person-centred' medicine' (Osborne, 1994: 519).*

Thus, Osborne purports that, in making the concept of the personal the cornerstone of General Practice, the profession sought to distinguish itself from other areas of medicine and so delineate its own ontology:

*'Person-centred medicine actually seeks self-consciously to turn the doctor's ethical persona into a clinical resource... the person of the General Practitioner, representing a particular style of clinical ethos, became determinative of the epistemological status of General Practice itself' (Osborne 1994: 519-520).*

In his view, then, the personal as a central facet of General Practice care is the product of the profession's concern to construct a specific identity and to achieve a high occupational status.

Bower and Mead (1998) support Osborne's explanation for the emergence of personal care within General Practice medicine. They also argue that the need to develop a specific and distinct professional identity during the twentieth century arose from the threat which General Practice was under from organizational changes within the NHS, specifically arising from the increasing power of hospital-based medicine. They contend that General Practice's



adoption of the concept of the personal resulted from the need to carve out a professional identity for itself which was quite distinctive from other areas of medicine. They argue its purpose was to provide General Practice with a particular and necessary role within the overall system of health care. Bower and Mead conclude:

*'The conduct of the patient-doctor interaction thus became of central importance to the doctrine of General Practice because it offered a theoretical basis for a kind of medicine that lacked complex diagnostic and treatment technologies at a time when technological expansionism marked out the more general terrain of medicine'* (Bower and Mead, 1998: 4).

However, they also argue that the adoption of person-centred medicine was not only the direct result of the need for General Practice to survive and be valued as a distinct area of medicine. They also contend that it arose from the growth of 'consumerism' as a political ideology in the 1960's. The vocal middle class, no longer prepared to accept the role of the passive patient in awe of the expert doctor, began to demand being treated as a whole person with an active and more equal part to play in the patient-doctor relationship.

May and Mead (1999) similarly contend that General Practice's adoption of the personal as a central plank of its identity helped to distinguish it from hospital medicine. However, they also regard this as emanating from a '*moral enterprise*' (May and Mead, 1999: 81) and, in this regard, refer to the bonds of personal obligation and trust that are foundational to the General Practice consultation.

Supporting the above, the current flurry of writing and interest in the topic of personal care may be seen as arising at a time when the personal in General Practice is under threat. The timing and impetus for this study can be seen in similar terms. It has been undertaken within a University Department of General Practice and was prompted by the concern of some departmental personnel about its imminent demise. In other words, this thesis itself may be historically located in this context, perhaps because organizational and social changes challenge the eminence of personal care and, so, threaten the identity of General Practitioners' claim to their specialism, which demarcates it from other areas of medicine.

Thus, the discourse of bio-psychosocial medicine has come to dominate, and arguably to form, General Practice medicine and lies centrally in the notions of the patient-as-person, the relationship between patient and doctor, consultation style and the communication skills that form essential components of doctors' array of treatments.

The work of Foucault has also been well critiqued. Criticisms include that his thesis takes a unilateral view of medicine as a regulatory force which controls social order through the disciplining of citizens' bodies. By so doing, the analysis fails to take account of what medicine has offered to the individual and society in terms of improved health and relief of pain and distress. Also, whilst dealing with both the issue of power at the macro level (absent from much interactionist work) and at the micro level of society (absent from structuralist work), Foucault's early thinking ignored the phenomenological (lived

experience) of the body, including the potential for the comfort of care.

Likewise, Foucault may be criticized for regarding all analyses of power and human action/understanding as the product of cultural discourse (that nothing exists beyond language), whilst he produces the only analysis not so deluded.

His methodology has also been criticized as flawed for drawing on official, historical texts rather than, for instance, data from '*ethnographies of how people in daily interaction contend with discourse and its effects*' (Huby, 1997: 210). Turner (1994) further asserts on this point that Foucault has used these texts selectively to support his thesis, rather than his thesis being induced from empirical evidence. Most particularly in this regard, his early work may be criticized for failing to take account of the patient's ability to act upon the strategies of power and to consider the role she plays in implementing or rejecting a particular type of subjectivity. Like most previous structuralist theorizing, Foucault's early work imputes patients with a passive role in medicine, as docile supplicants, duped into collusion with the *disciplinary* exercise of power (Lupton, 1996 and 1997 b; Moss, 1998; May, 1992 b).

However, the work of Foucault is the one perspective that offers a theoretical understanding of the personal as a socially constructed concept. Further, as I will outline in the final chapter, his later work deals with some of these criticisms and offers a promising framework for understanding the findings of this study.

I commented previously that, to date, there has been a paucity of work, which has explicitly examined lay and health care professionals' accounts of the concept of personal in primary care. I now turn to the one exception identified; the recent study by Preston *et al.* (2001).

### **The Meaning and Importance of Personal Care: An Empirical Study**

Preston *et al.* (2001) examined how both patients and service providers in primary care construct the meaning of personal care and whether, when and how it is of importance and value. Since this study most resembles my own in terms of research aims and methodology, it is worth outlining its main conclusions in some detail.

Recognizing the lack of work to have problematized the notion of the personal, the first aim of Preston's *et al.*'s study was to explore what healthcare professionals and patients mean by personal care. They acknowledge that previous definitions tend to be researcher-generated and, instead, they sought to allow meaning to emerge from patients and from health care professionals themselves. The latter included all members of the primary care team, including nursing and reception staff. The study's second aim was to understand how important personal care was to patients and practitioners, and whether it was more important in some situations than in others. This aim also reflected the research hypothesis that such care is traded-off against other priorities and, in certain situations, might be considered to have 'dis-benefits'. Thus, the study challenges the established assumption that care with a personal component is intrinsically beneficial and always desirable.

A qualitative methodology was used that comprised a semi-structured topic guide for individual interviews, and with post-interview focus groups to *'validate [and] fill any gaps in the information collected'* (Preston *et al.*, 2001: 14). A thematic analysis was undertaken and Framework Analysis used (Ritchie and Spencer, 1994) to enable the thematic findings to be mapped to the research questions and for comparison across study groups.

The main finding relating to the meaning of personal care was that it was constituted in three ways. First, it was talked about as care within a *'brief encounter'*, characterized by the doctor treating the patient in a humane and empathetic fashion. This focused on the doctor's consultation skills, such as listening and showing empathy, and on the patient's treatment being *'individualized and not generic'* (Preston *et al.*, 2001: 2). This individualization included the doctor seeking information about *'their families or other relevant parts of their lives'* (Preston *et al.*, 2001: 21).

Second, it was constituted as care that occurs within the context of the patient-health care practitioner relationship afforded by continuity over time with the same service provider. This care was characterized as *'being treated as a human being both within individual encounters and from one encounter to the next'* (Preston *et al.*, 2001: 30). This involved the practitioner getting to know the patient, using increased knowledge to ensure consistent and appropriate treatment for that individual, and generally providing the context in which to build *'mutual respect, trust and commitment to the continuing relationship'* (Preston *et al.*, 2001: 30).

Third, however, the study found that personal care was defined as not only occurring within the context of the individual consultation with a known practitioner (dyadic situations), but also within the context of the primary care team. This consisted of patients feeling that the practice as a whole treated them (and one another) in a '*human way*', and involved interpersonal skills such as friendliness, as well as communication amongst team members in order to provide the necessary care to the individual patient.

Fourth, these meanings were found to be similar across study participants. Any differences were not related to different patient groupings but between different practices. Thus, this study shows how organizational context impacts on service providers' and users' meaning construction of the concept of personal care.

The main findings in relation to the value of personal care were that healthcare professionals and patients both valued personal care and attributed many benefits to it. These included; encouraging '*appropriate*' consulting behaviour, helping the patient feel more at ease in the consultation and to disclose more information, improved self-report health outcomes, lower care costs, and greater service provider and patient satisfaction.

Personal care was found to be traded-off in certain situations. The factors which featured in this decision-making process were complexity of the problem, the problem being urgent and the emotional salience of a problem for patients. Indeed, the differences in the degree to which patients valued personal care

were found to be associated not with patient groupings, but with the health problem itself:

*'The nature of the consulting problem had more impact on the priorities than the patient's gender, age or occupation'*  
(Preston *et al.*, 2001: 47).

Dis-benefits were identified as doctors having a lack of time and the demand such care could place on strained resources, both material and those of the service provider personally.

This work makes an important contribution both in methodological and substantive terms to this neglected subject area. Its start post-dates the commencement of this thesis and it adopted my own research aims and methodological approach. It, therefore, is considered to have lent support to the work I have undertaken, and, in particular to the epistemological and methodological approach I had already embarked upon. In addition, my thesis can, using this now reported work as a reference point, build on and extend it in a number of ways by developing further some of Preston *et al's* findings, by producing some that are new, and, most particularly, by theorizing about them sociologically.

## **Summary and Conclusion**

In this chapter, I have explained that care with a personal quality is a key feature of the history and working ethos of General Practice. Indeed, there is substantial evidence that it is of central significance to the self-image and

rhetoric of General Practice. Despite this, there is a paucity of either theoretical or empirical work which has examined the personal explicitly, as a topic worthy of study in its own right. Instead, the personal has an underlying and implicit presence in most General Practice-oriented and sociological work, and lay accounts of this concept are particularly notable by their absence. The personal has remained opaque and elusive; an essential but taken-for-granted feature of the landscape of General Practice.

Personal care has been conceptualized by General Practice-oriented research and within sociology in two main ways; within the context of the patient-doctor relationship built over time and in terms of consultation style within each individual encounter. In empirical work, these conceptualizations have typically been operationalized as: frequency and duration of patient-doctor contact; patient and doctor identification with one another; the doctor knowing or having a sense of responsibility toward the patient; doctors' values and attitudes, including being egalitarian and sharing power; doctors' consultation skills and manner, including having a conversational style, asking open questions, encouraging the patient to be open and express themselves fully and to participate in decision making; enablement; and, generally, taking a bio-psychosocial approach that entails treating the patient as a whole person and focusing on the 'illness experience' and not just clinical symptoms.

Patient and doctor subjectivity are the trademark of these constructions. The personal is conceived in terms of the patient's individual understanding and experience of the problem. Patient subjectivity and the patient's wider life



context have become the doctor's rightful and necessary spheres of reference for resolving medical problems. Indeed, the legitimate scope of medicine extends beyond the biological to wider concerns in the patient's domestic and social life. Likewise, the doctor's subjectivity has a significant presence; her own individual characteristics, persona, values and attitudes are seen to play an important role in the practice of good medicine, and are used as proxy measures of quality care.

Empirical work on care with a personal component, however defined, shares some common features. A quantitative approach is the predominant methodology adopted and focus has, therefore, rested substantially on measuring the component parts of the interaction between patient and doctor against pre-set outcomes. The assumption inherent in such thinking is that care with a personal component may be reduced, defined and measured through examination of the minutiae of the component parts of the interaction and outside the greater whole of the wider context, such as the experience of the ongoing relationship with the doctor or the patient's understandings and everyday life circumstances. Outcome measures have been the preferred criteria of measurement for quality and efficacy, rather than the process of care and the patient's experience of that care. The definition and criteria of what constitutes personal care, and by implication good care, are usually researcher- and not patient-driven.

There is some empirical evidence of health benefits to patients from continuity of care and from a patient-centred consultation style, although this is not a

universally finding. There is more compelling evidence that care with a personal component is associated with greater expressed patient satisfaction. Again, however, this is not without challenge. Studies that ask patients what they value about care from the GP are more consistent in showing that patients highly value attributes usually associated with personal care and that they are often prioritized against more technical criteria. In all respects, the benefits and value of such care are shown to vary by patient groupings.

Moreover, there has often been an assumption that care with a personal component is inherently positive. This is testified to by the extent to which a conceptualization of the personal has been used as a proxy measure of quality care. The doctor who adopts such an approach is constructed as humane and liberal and as always having the best interests of the patient at heart. General Practice medicine that focuses on care of the patient-as-person is regarded as beneficent and essentially positive. This assumption is challenged by the sociological literature, much of which perceives medicine as an instrument of social control or surveillance, a means by which power is exercised, and which focuses on the asymmetry of power in, and the conflictual nature of, the patient-doctor relationship.

Some atypical work has treated the personal as a problematic. This work suggests the development of this concept is historically and socially located. It has been embraced by General Practice to construct an identity that demarcates it from other branches of medicine and emerged as part of a wider adoption of 'personhood' by medicine and allied professions in the twentieth century. The

emphasis of the patient-as-person in medicine is considered to represent part of a much broader social transformation from *sovereign* to *disciplinary* power. Only one known empirical study has sought lay accounts or those of healthcare providers about what personal care means and what importance it holds. However, this has not brought a sociological understanding to bear on personal care as a concept.

# CHAPTER THREE

## Methodology and Study Design

*'Central to constructionism is the premise that human beings are agents rather than passive organisms or disembodied intellects that process information. It is undeniable that human actors process information, but the process is carried out in the context of cultural practices and purposes, not to mention beliefs and sacred stories' (Sarbin & Kitsuse, 1994: 2).*

### Introduction

I showed in the literature review that most work carried out around the topic of the personal in General Practice takes as a starting point that the personal 'is' something. It is a taken-for-granted concept that has an implicit, underlying presence in related areas of thinking and research. Thus, there is an assumption that personal care exists as an entity with a priori meaning that is axiomatic, universal and static. I outlined what I perceive to be the gaps in existing literature that this study focuses on, and I specified the study aims in relation to these gaps. Here, I discuss how the study aims also reflect the epistemological perspective I have adopted and how that has led to a methodological approach based in the tradition of interpretivism.

This chapter is split into three main sections. First, I discuss the methodological approach taken, consider the philosophical underpinnings of that approach, and explain the process by which I arrived at the choice of methodology. I argue that the study aims developed both from the gaps in literature and my 'preferred world view', and these aims informed the decision to undertake a qualitative interview study. I also discuss the status being attributed to interview data and contend that language is both representational and constitutional in nature. Second, having described the methodological approach, I move on to the detail of the study design. I outline the sampling frame, the strategy for access to and recruitment of participants, the significant recruitment problems encountered and I reflect on the limitations of the study. Third, I describe the process and methods of data management and analysis, including use of the qualitative analysis software, NVivo, Framework Analysis (Ritchie & Spencer, 1994) and more traditional paper-based methods.

I have sought at all stages to be reflective about and reflexive in my research practice, and I incorporate some of these reflections on both ethical and practice issues in subsequent parts of this section.

## **Study Methodology**

### **The Philosophical Underpinnings of Interpretivism**

The approach taken in this study lies broadly within an interpretivist school of thought. Interpretivism encompasses many perspectives, such as symbolic interactionism, ethnomethodology, phenomenology and social constructionism.

But, as a philosophical tradition, it holds specific underlying assumptions and emphases of interest in the social world. Also, like any school of thought, interpretivism does not '*specify particular research techniques*' (Atkinson, 1995: 122), however, some methods are more congruent with it than others (Silverman, 1995; Mason, 1998; Seale 1999).

Weber, writing in the nineteenth century, is credited with being the first to provide a robust challenge to the domination of structuralist approaches in sociology; approaches which assume social behaviour is conditioned or shaped by forces that reside at the level of society as a whole (Keat and Urry, 1982; Cuff *et al.*, 1992). Weber's concept of '*the action frame of reference*' underpins interpretivism's concern with the relationship between meaning and action. Whilst his aim of developing a methodology that allows sociology to combine the notion of *verstehen* (understanding) with the capacity to identify and follow general scientific laws is not considered to have been successful, nevertheless, he is noted as having pioneered '*the action frame of reference as an approach to the study of social life*' (Cuff *et al.*, 1992: 143), which lies at the centre of the interpretivist paradigm.

The philosophical roots of this perspective can also be traced to the work of Mead, Husserl and Wittgenstein, amongst others (Cuff *et al.*, 1992: 143). They share certain commonalities adopted by those taking an interpretivist approach to the study of the social world. These include the importance of language, not as reflecting, but as constituting, social life and the central importance of obtaining the actor's point of view in understanding social life. Schutz is also a

key figure in the history of the development of interpretivism and described as having an important influence in the development of the ideas of thinkers such as Weber and Husserl (Heritage, 1984). Heritage explains the main premise of Schutz's thesis:

*'... the social world is, in the first instance, experientially interpreted by its members as meaningful and intelligible in terms of social categories and constructs'* (Heritage, 1984: 45).

Schutz, then, focuses the interest of social science on the subjectivity of social actors and those actors' understandings of mundane, everyday, common-sense knowledge. He does not, however, imply that the social scientist can gain direct access to what another person 'actually' experiences or to their individual 'reality'. An understanding of those experiences, however, can be gleaned through the use of *'learned common-sense constructs of actions, events and their contexts'* (Heritage, 1984: 49). Despite some limitations, Schutz concludes that studying social life in this way is sufficient to achieve an understanding of social reality because common-sense knowledge is shared through our mutual socialization. Schutz distinguishes this approach to knowing the social world from that of positivism in the natural sciences:

*'The world of nature, as explored by the natural scientist, does not 'mean' anything to molecules, atoms and electrons. But the observational field of the social scientist – social reality – has a specific meaning and relevance for the human beings living, acting and thinking within it. By a series of common-sense constructs they have pre-selected and pre-interpreted this world which they experience as the reality of their daily lives. It is these thought objects of theirs which determine their*

*behaviour by motivating it* (Schutz, 1962: 59, quoted in Heritage, 1984: 16).

Indeed, this thinking of Weber, Schutz and others underpins the departure from positivistic scientism that dominated much of the 20<sup>th</sup> century in both the natural and social sciences (Altheide, 1977; Heritage, 1984). Altheide notes that Kuhn's 'Scientific Revolution' (circa 1962) began this process by raising objections to positivistic notions of 'value-freedom' and 'mind-independence'; axiomatic assumptions that the social world may be investigated with objectivity to reveal the 'truth'. Departing radically from this position, interpretivism does not regard science as separate from the world it studies, but as arising and existing within a specific social and political context. Being affected by such interests, it is characterized by discontinuity and changes over the generations. It is also axiomatic that the researcher's characteristics have an influence on the knowledge gathered, and this has resulted in much attention being paid within this paradigm to researcher reflection and reflexivity.

Further, it is axiomatic to this tradition that society is created by its members and that, *'if [people] define their situations as real, then they are real in their consequences'* (Collins, 1988: 265). There are no absolute 'facts' about the world waiting to be discovered, only multiple realities that are variously constructed and co-exist and, thus, the social world is socially constructed. People observe, interpret and construct meaning through interaction. To be more precise, this approach acknowledges and allows for the idea that:

*'... social objects are not given in the world but [are] constructed, negotiated, reformed, fashioned and organized by*



*human beings in their efforts to make sense of happenings in the world'* (Sarbin and Kitsuse, 1994: 3).

One task of social science is to examine how these meanings are constructed and what their impact is on individuals and society.

Thus, the emphasis of the approach is to explore the so-called mundane in social life, the minutiae of the everyday, common-sense meanings people attribute to their world. This is congruent with my own 'preferred world-view' in the examination of the study topic. From the outset, I have not seen personal care as something in an absolute sense, regardless of social context, but as a concept that exists in this space and time. I also regard it as likely to be defined and valued in a more fluid and context-dependent way than previous methods were capable of revealing. This means the study's purpose has been defined as exploring the common-sense understandings attributed to the idea of personal care within the context of peoples' daily lives, rather than operationalizing and measuring it against outcomes or comparing its relative value to other patient priorities.

### **Making Choices: Deciding on Methodology and Study Aims**

Some writers in social science contend the methodology used in any study should, or at least can, be led by the nature of the research questions asked (Paton, 1987; Mason, 1998; Seale, 1999). In my case, the questions did drive the methodology. However, both the questions and the methodological approach arose from my preferred 'world-view'. There had to be some fit between the

area of research and a philosophical position with which I felt comfortable in order to maximize the interest and value the study held for me. Thus, my view of how we can know the social world had an important place in the decisions taken on the research aims and, therefore, methodology adopted.

When I began the Ph.D., the proposed research aims were, first, to explore the meaning of personal care in General Practice to patients and doctors and, second, to consider how its importance and value varies according to patient groupings. The first aim was to be tackled by qualitative interviewing. Having found *the* definition of personal care, it would become the basis for tackling the second aim via a quantitative survey of a cross-section of the population in order to identify the hypothesized varying levels of importance by characteristics, such as health status, age and class. This approach is supported by previous work which suggests that personal care is of greater importance to elderly and chronically sick people (Freeman and Richards, 1990; Al-Bashir, and Armstrong, 1991) and by some evidence that there is a differentiation between socio-economic groups in this regard (Liaw *et al.*, 1992).

These questions share the same underlying, implicit epistemological assumptions of previous work in this field. They draw on what many of those within a positivistic school of thought contend; that a singular and static definition of what personal care 'is' has the capacity to be discovered. Further, by supposing the level of importance can best be determined by reference to specific patient characteristics at a population level, they assume the importance of personal care is a constant feature of each individual's life. I do not suggest

that these proposed research questions and methodological approach are wrong, deficient or lesser. This type of approach has yielded important knowledge of the social world, and made a significant contribution to understanding it. Similarly, I reject the tendency to regard different methodological approaches as mutually exclusive alternatives. These perspectives, and the research practices associated with them, are not polar opposites and suggestions that they are have been rightly criticized (Berger and Luckman, 1967; Millburn *et al.*, 1994).

Indeed, Atkinson (1995) makes the point that paradigms are often juxtaposed in methodological writing and teaching as mutually exclusive opposites. He recognizes this may be seen as the product of a social process by which knowledge is '*assembled, legitimised, and reproduced*', often to satisfy the need of vested interests that wish to create a '*domain of expertise*' (Atkinson, 1995: 118). I agree with the conclusion that a major problem with the construction of such tightly-bounded categorizations is that they are translated into dogmatic prescriptions of how research should and should not be done. The danger of this has been the postulation that '*paradigms*' are inherently in conflict and are inextricably linked to specific methods which cannot be combined. Seale (1999) reminds us that these traditions are part of an historical and cultural landscape which informs our thinking. He refers to them as '*moments*' in time which can be drawn upon to explore the social world and maintain quality in the research endeavour, not as substitute or competing '*truths*'.

However, each methodological approach reflects a particular epistemological perspective and the findings produced are, in this sense, artefacts of these. Therefore, consonance between the researchers' world-view, research aims and methodological approach is clearly desirable (Mason, 1998). As my starting point was that personal care is a socially constructed concept, and one that people attribute meaning and value to within an everyday social context, research aims and methodology usually associated with a positivistic tradition were not considered apposite. As a reminder, the research aims of the study are to explore:

- How patients and doctors construct the meaning of personal care in General Practice and
- What importance and value, if any, patients and doctors place on personal care, and in what contexts.

It is well established in sociology that meaning, experience and perception are best examined using a qualitative approach (Sarbin and Kitsuse, 1994; Dowell *et al.*, 1995; Mason, 1998). This approach takes account of the fact that the meaning assigned by people to phenomena is not static, universal or unitary, but is created and shifts within a social context. In exploring peoples' perceptions and experiences of the concept of personal care, the study clearly needed to take an inductive approach, where theory is generated from the data, rather than a deductive one, where data are used to test out or falsify some pre-existing theory. This is in direct contrast to most of the patient-doctor

consultation and relationship research previously carried out, as discussed in the literature review.

The specific method chosen to achieve these aims was a semi-structured interview that asked open-ended questions (the guides used are set out in Appendices A and B). I considered this method would be the most effective way of gaining access to the complexity of the socially constructed meaning of the concept and the '*contextual, situational and interactional*' nature of this knowledge (Mason, 1998: 40), and would give the flexibility needed to explore previously unformulated, emerging ideas and areas of interest.

However, it is noted that such choices were also made possible by my research context. Like all research, the social and political context in which the study was undertaken played a role in influencing its development. My particular research context afforded a good degree of latitude when undertaking this piece of work than is usually the case. The research aims, and method of choice, for instance, were made feasible by the greater freedom allowed in the process of this Ph.D. I am aware that, in many research contexts, the aims and even methodology of work, are influenced or entirely determined by grant awarding bodies and/or grant-holders. As Barbour notes:

*'Qualitative researchers stress the importance of context but sometimes forget that research itself is carried out against an ever-changing backdrop. Now that it has secured a place in the methodological mainstream, qualitative research is increasingly being influenced by funding and editorial bodies' (Barbour, 2001: 1115).*

Other aspects of my research context have played a part in the development of this study. Having settled on the epistemological approach from which the *type* of research aims ensued, as indicated earlier, the *specific* research questions arose largely from gaps in knowledge identified in the literature review and from an understanding of the policy context. In this way, I sought to make the study topical and relevant to academic and practitioner communities, as well as to improve the possibility of being awarded the degree. So, whilst I contend that my research aims arose from my preferred world-view, and acknowledge the relative freedom afforded me by the Ph.D. process, the wider context and purpose of the study and my own self-interest also played a part in its development.

The relevance of the social context to this thesis may be considered in a wider sense beyond the immediacy of my circumstances and personal purpose. As I mentioned in the literature review, Armstrong (1979; 1982; 1984), amongst others (May *et al.*, 1996; May and Mead, 1999), takes Foucault's line that the development of the emphasis of the patient-as-person in medicine was part of a much broader social transformation from *sovereign* to *disciplinary* power. He argues these developments within the medical profession are paralleled in social science, where medicine's construction of the patient as an individual, idiosyncratic being is mirrored in the recent tradition of making the research participant the subject of '*observation, description and analysis*' (Armstrong, 1982: 117). The fact that the focus, indeed the *raison d'être* of this study is to obtain patients' views of personal care, and that these are privileged over GPs', may be considered in the same light. Arguably, then, this study can be seen as a

product of this wider social and historical development and as supporting the further perpetuation of the discourse of the personal in General Practice medicine and social science.

### **The Epistemological Status Attributed to Interview Data**

Consideration of the epistemological underpinnings influencing the aims and methodology of this study also required me to contemplate the status attributed to interview data. I reflected on the relationship between epistemology and method but, this time, in relation to the data themselves. I now consider what epistemological status I have attributed to language and, so, to the interview data I have gathered.

Silverman (1995) points out that there are three major ways in which interview data can be viewed. For the sake of brevity, I greatly simplify these debates in the following discussion. There are some overlaps across these approaches and disagreements within them. However, broadly speaking, they can be distinguished as positivism, interpretivism and ethnomethodology. Each takes a distinctive view of the status of interview data.

First, in the positivist paradigm, objective 'facts' are thought to exist in the world and can be accessed and discovered through a good study design. The main aim of such research is to collect data that will illuminate these facts by ensuring data are valid and reliable. Such data exist independently of the research context and the interaction between the researcher and researched. This means that removal of bias is a central tenet of the approach and emphasis

is placed on strict adherence to a pre-determined study protocol in order to reduce 'researcher bias'. Statements from interviewees can be, and usually are, treated as accurate or inaccurate, true or untrue, by building checks and balances into the study design. The researcher is the final arbiter on the reliability of the interviewee and the validity of the data given. Interview data are treated as corresponding to the world 'out there' and language as giving direct access to the single 'truth' that exists in the world.

Second, departing considerably from this view, within the interpretivist tradition, interviews are not simply representations of the world but are part of the world they describe. Interviews are in themselves social events. Data cannot give us access to 'facts' about the world 'out there', independently of the research setting and interaction. Here, differences in research context are not perceived as a barrier to gaining valid information. What the positivist tradition considers as problems of interviewing, the interpretivist tradition regards as rich sources of information about taken-for-granted properties of interaction in the social world. Data, then, are treated both as a resource that allows access to the social world and as a topic of study in their own right. Given this, data must be interpreted against the background in which they were produced, taking account of the researcher-participant relationship. Nevertheless, the data are seen to relate to the interviewee's 'reality', as reporting on her experience in the social world outside the context of the research interview. However, many following this tradition accept that multiple realities co-exist and that no one reality should be privileged over another.



Last, the tradition of ethnomethodology shares some of the assumptions of the interpretivists by agreeing that there are no objective 'facts' that exist 'out there' in the world and can be accessed independently of the context in which they were created. However, it departs significantly by viewing interviews only as a source of data that show culturally derived conversational practices and narratives of the participants. Language has no relationship to the world outside, as there is no reality beyond the interview, only the world we create through interaction and discourse. Emphasis is on what participants are doing *in* their talk, rather than what they tell us *about* the social world. Work being done in the interview is regarded as a 'local accomplishment'. So, data only report upon and express their own structures.

Because I have sympathy with both interpretivist and ethnomethodological approaches, I spent much time early in the Ph.D. trying to reconcile these two apparently competing positions. I wondered why these positions are often discussed as dichotomised and oppositional choices. I concluded that the relationship between language and reality is a complex one, with each being inextricably linked to the other. Choosing one position over another would lead to an oversimplification of this complex relationship. Indeed, Silverman raises this point, challenging the notion that we must choose between seeing interview data either as potentially true accounts or as situated narratives. He concludes:

*'... in studying accounts we are studying displays of cultural particulars, as well displays of members' artful practices in assembling these particulars'* (Silverman, 1995: 114).

After much existential angst about the purpose of life in research if the latter position were adopted entirely, I abandoned the quest to reconcile what I now consider irreconcilable and have settled on what some have called a 'subtle realist' approach (Hammersley, 1992). The approach of 'subtle realism' has emerged out of these paradigmatic debates. Following the thinking that paradigms are themselves social constructs which may harmfully bound research practice, subtle realism incorporates an awareness of the world, and research accounts, as socially constructed. However, this is not applied wholesale to research practice, accepting instead that language is referential to a reality outside the text. Thus, this perspective offers a pragmatic way forward. It allows use of the important lessons from different traditions in pursuing quality in the research endeavour, without having to reconcile such philosophical points at the outset. Seale puts it like this:

*'Practicing researchers can learn to do good work from a variety of examples, done within different "moments", without needing to resolve methodological disputes before beginning their work' (Seale, 1998: 8).*

He warns against uncritical and unreflective practice, encouraging constructive engagement with methodological debates without necessarily having to 'resolve paradigmatic debates in advance (Seale, 1999: 3). He regards the different methodological perspectives as '*tools*' that can be utilised by researchers in the '*craft skill*' of research practice. The approach I am taking, then, does not require a stark choice to be made between seeing language either as representational or constitutive. Language is treated in this study as a resource and as a topic of enquiry. Further, this perspective acknowledges that, like the concept of

personal care in General Practice, research philosophy and methods are also social products existing in space and time and are not themselves absolute truths, but socially constructed ways of 'knowing' the world.

So, what does taking this approach to language mean for this study? I accept that interview data are potentially factually correct statements that reflect some external reality about health care in General Practice. I also accept they represent culturally-derived conversational practices which are the product of, and do specific 'work' within, the context of the interview. This combined approach is evident in the analysis of the data presented in the three findings' chapters. I now look more specifically at what the implications of this are for the management and analysis of the study data. Thus, having discussed how the study aims and methodology were determined, the epistemological status of interview data, and the social and political context in which this study is located, I now detail the study design.

## **Study Design**

### **Introduction**

In this section, I start by describing the exploratory work carried out at the beginning of the fieldwork and explain the purposes of this early work. I then outline the main study design, including the rationale behind the sampling strategy and the methods used for recruitment. I summarise and reflect on the significant recruitment problems I experienced, and discuss the implications for

the validity of the study's findings. This leads to a general consideration of the study's limitations.

### **Exploratory Work: Purpose, Sampling and Reflections**

In keeping with good qualitative research practice (Mason, 1998; Paton, 1987; Cornwell, 1984), exploratory work was undertaken at the outset of the study. This involved doing one interview with eight patients and six GPs. This work had several purposes; to sensitize me to the topic, allow initial exploration of how interviewees talked about personal care, including the language used, and help to develop a more robust study design and rigorous interview technique.

Taking an inductive approach necessitated constantly being open to new themes and ideas and being responsive in thinking about and executing the work.

Beginning the study with research that was specifically aimed at exploring patients' and doctors' accounts of personal care, and assessing the efficacy of the methods employed in this exploration, were an important part of this reflexive approach. As Mason explains:

*'... if you are working with an ontological and epistemological model where theory is generated from empirical data, and data generation and sampling decisions are made in the light of evolving theoretical analysis, then you cannot - and will not want to - specify in advance all the details of your research design, numbers and types of cases you will draw on, and so on' (Mason, 1998: 33).*

In keeping with this approach, the exploratory phase was effective in a number of ways. First, it allowed initial exploration of how patients and doctors constructed the concept of personal care. The data gathered informed the general conceptual areas and specific questions to include, as well as the best language to use in interview guides for subsequent work. Second, it helped to refine the methodological approach and research design. This included deciding on issues such as: sample selection; initial numbers of participants to be approached; the best method of accessing and contacting interviewees; and the number of interviews to hold with each respondent. I also used this early work to decide on the methods of managing and analyzing the data. One further purpose was to explore whether children should be the focus of study. This question arose from my own particular interest in children, specifically in the sociology of childhood, and I wanted to test whether such a focus would be useful and possible. Last, it gave me the opportunity to experience the research process for my own learning purposes; in particular to practice doing research interviews and to generate and analyze themes from the data prior to embarking on the main part of the study.

The exploratory work involved interviewing eight patients from two practices and six GPs from three. One patient interview was with a couple and, consistent with the approach taken to the whole study sample, couple interviews are counted as one case. A range of practice size has been included in the study due to expressed concerns that recent organizational changes, including the growth of large practices, has resulted in the erosion of personal care. I summarized these changes and subsequent concerns in the introduction

to this thesis. This is supported by empirical work that smaller practices offer care with a more personal quality (Baker & Streatfield, 1995; Howie, 1999), outlined in the literature review. The sample included at least one large and one small practice, defined by numbers of doctors working in the practice. A small practice was defined as having three or less GPs and a large practice as having four or more GPs. Exploratory work included one small and two large practices.

Socio-economic variation in the areas where the practices were situated was also built into the early design. I had a hunch that personal care might be more important to those living in a relatively deprived area, and this is supported by empirical evidence of a positive association between patient preference for personal care and having poor health. Indeed, Al-Bashir and Armstrong (1991) conclude:

*'A higher proportion of those with poor self-rated health preferred a doctor who offers treatment through personal attention rather than drugs...'* (Al-Bashir and Armstrong 1991: 8).

This allowed a comparison to be made of the meaning and importance of personal care across different socio-economic areas. Since the link between deprivation and poor health is well evidenced, it seemed reasonable to explore whether deprivation might also be associated with the value placed by people on personal care.

For the sake of speed and ease of access, I contacted GPs known to this department (General Practice), who fitted the design criteria and might look favourably on taking part. They were approached by a letter, with a study information sheet enclosed, and followed-up by a telephone call (see appendices D and E). All six doctors approached from the three areas agreed to take part. The deprivation scores of these areas varied. Deprivation scores for the Lothian Health Board area range from 5.48 to -4.13, where a high score represents the worst level of deprivation. Also, the Health Board list of deprivation shows the relative position of each practice in the Lothian area. Table 1, below, shows the deprivation score and whether the Health Board ranking is high or low for each of these practices and the numbers of doctors who took part from each. The numeric Health Board ranking is not specified as this is a unique identifier of each practice.

Again, for speed and ease of access at this early stage, all patients interviewed were identified and approached by participating GPs. My interest in children led me focus on families (defined as households with at least one child) and, so, GPs were asked to approach only patients with children aged one to ten years old. GPs were also asked their opinion on the feasibility and desirability of taking such a focus. Of the ten patients approached by letter (see appendix G) and then phone, eight agreed to be interviewed. Preliminary patients were sent a further information sheet and, if contacted, asked to complete a form indicating their consent to participate in the study (see appendices H and K). Table 1 also shows the numbers of patients who took part from each.

**Table 1: Exploratory Work Practices by Practice Size, Deprivation Score and Lothian Health Board Ranking**

Practice	No. Doctors	No. Patients	Practice Size	DepScore	Ranking
P1	3	4	Small	-1.4	Low-Middle
P2	2	4	Large	-2.74	Low
P3	1	0	Large	4.25	High

(See appendix C for details of practices and patients).

As Table 1 shows, none of the patients from the most deprived practice area, P3, were recruited to the study, as they did not respond to several attempts at contact. No children were interviewed at this stage. Instead, patients were asked about their understanding and experience of personal care for themselves and their children. As patients were being recruited through Lothian Health Board, ethical consent was sought and approved by the local Ethics Committee. A commitment was given to the Ethics Committee to maintain the confidentiality of all those taking part in the study. Therefore, I have anonymised all patients and doctors by giving them pseudonyms and attaching numbers to each practice and all patients.

The preliminary work was successful in its aims. It helped me to orientate to the topic under study, refine the areas to be covered in the interview guide, understand the best language to use, and alerted me to the more conceptual themes of potential importance. It was also extremely useful in helping me



make informed decisions about the specifics of the study design. A summary of the main points that emerged in this respect are discussed below:

First, there was some evidence practice size might be an important factor in how patients defined the concept of personal care. This variable was, thus, deemed as worthy of continuing inclusion in the study design. No variation was evident in deprivation score but, as this may have been due to a lack of patients from the more deprived area taking part, I decided to retain it as a variable. So, the sampling frame for the rest of the study contains both small and large practices from two socio-economically distinctive areas.

Second, GPs talked positively about personal care, but with some comment on its potential disadvantages. However, patients talked almost exclusively in a positive way about what getting personal care from the doctor meant and its importance to them. Most expressed high levels of satisfaction with the service, some of 'liking' their doctor and even of having a 'close' relationship with them. The data were useful in elucidating how personal care was being constructed and valued. However, they were also noteworthy for the lack of critical comment about situations, for example, where personal care might have been needed but not given. In addition, most patients stated they had agreed to take part in the study as a 'favour' to the doctor. Doctors appeared to have approached their 'favourite' patients, who had agreed to be interviewed out of a sense of 'loyalty', and some patients stated this quite explicitly. Patients may have also associated me closely with their doctor due to doctors approaching their patients directly on my behalf. I was concerned that this recruitment method had produced a highly selective sample that could impede patients'

ability to express more varied views on their care and, thus, would narrow the range of comment. I concluded that the remainder of study interviewees should be more randomly sampled and directly recruited.

A third point to emerge from the exploratory work was that interviewees often talked about intimate and emotionally-charged issues. Perhaps reflecting my naivety at the outset, I was surprised at the extent to which personal details were revealed during these discussions. It seemed that accounts of what personal care means to patients entailed giving 'private' information. Some interviewees described the meaning and importance of such care from their doctor through relating stories of particular difficulties or crises they had experienced in their lives. This was mirrored in doctors' accounts, who also discussed personal care in such terms for patients. Early discussions brought up issues, such as bereavement, alcohol and substance misuse, sexual abuse, incest, and separation and divorce where feelings were still obviously raw. They also talked about crises in their own lives and their experiences (in the case of doctors' interviews, those of patients') of emotional and mental distress, and the difficulties of dealing, for instance, with the long-term multiple health problems of a child who had been expected to die but was surviving against the odds.

Patients told me such private stories to explain their understandings and experiences of personal care. They seemed to move between accounts of personal care that may be classified as 'public'; what is deemed acceptable for public consumption, and 'private'; inner, personal and restricted to specific contexts (Backett, 1989; Cornwell, 1984). Drawing on Goffman's thesis on

'*impression management*' (Goffman, 1956), Cornwell postulates that, in the context of the research interview, interviewee accounts change over time as the relationship develops. She contends that, as interviewee and interviewer become more familiar, the former move from public accounts to private ones. She defines public accounts as:

*'... sets of meanings in common social currency that reproduce and legitimate the assumptions people take for granted about the nature of social reality. ... the person doing the talking can be sure that whatever they say will be acceptable to other people. Public accounts... conform to the "least common denominator morality"' (Cornwell, 1984: 15).*

On the other hand, she defines private accounts as:

*'... spring[ing] directly from personal experience and from the thoughts and feelings accompanying it' (Cornwell, 1984: 16).*

Like Cornwell, I do not contend that private accounts are more 'valid' than public accounts or that they bring us closer to some absolute 'truth', only that they are more consonant with the topic under research, open up ways of telling about and hearing people's experiences of health care and, so, may bring us closer to an understanding of them.

The implications of this discovery were twofold. First, uncertainty about whether to focus on children was settled. Exploring a subject rarely tackled by a qualitative methodology, and one which gives rise to discussion of sensitive information, made a focus on families with young children where only parents were interviewed a sufficiently challenging prospect. The exploratory work also

indicated that accounts of personal care in relation to adult patients, their children and possibly even their own parents, that is across three generations, could be accessed through this focus and sampling frame. Furthermore, it appeared from doctors' accounts that most children between the ages of five to sixteen rarely come into contact with primary care services and, thus, concentrating on families more generally was preferable. Thus, I took the decision not to interview children directly either in the main part of the study.

Second, I decided that two interviews, rather than one, should be carried out with all subsequent patients with about two weeks between. The concept of personal care could only be fully explored through accessing both types of accounts and the study design needed to facilitate this in order to enhance the quality of the data. I thought having a second interview would encourage interviewee and interviewer to relax and this would support access to these different accounts.

A further benefit of having a second interview with patients arose from discovering during this early phase that the term 'personal care' was not commonly known or used by many patients. Some had no understanding of the term or guessed at its meaning as, for example, relating to residential care of the elderly or providing physical care to a person with a disability at home. Both uses of the term are valid, of course, but would not attend to the study aims of examining the concept of the personal within the context of the GP-patient configuration. In effect, it appeared to have little immediate salience to many patients and, consequently, extra effort and negotiation at the outset of the

interview with the participant were required, taking up interview time. Some interviewees had to orientate themselves to the study, having been unclear at the initial approach about its exact focus. Having a second interview allowed for this, and gave time to cover the interview guide fully, as well as any new ideas that arose from discussions.

A second interview also provided me with the opportunity for both participant and researcher to consider what was said at the first interview and to develop further ideas and narratives that express those ideas. Talking about personal care seemed to raise forgotten experiences to peoples' consciousness and new ideas were forged between the interviews. In other words, the process of the interviews helped people develop their thinking on personal care, and a second interview allowed a further opportunity to explore this. It also facilitated moving from general questions to more specific ones, which could be couched in the interviewees' own language and stories developed from the initial encounter.

Perhaps unsurprisingly, doctors did not show the same level of uncertainty about the term, personal care, and discussion of its meaning and value also did not involve them in talking about sensitive issues in their own lives. In addition, there were practical difficulties in doctors giving time to more than one interview. Thus, one interview was considered sufficient with the remainder of the GPs who took part in the study. All patients and doctors involved in this exploratory phase were included with interviewees from the main part of the study in the analysis.

More generally, the problem of terminology in patients' accounts revealed by the early work presented a considerable challenge to how the main part of the study should proceed. As I was trying to understand the meaning and value that patients and doctors attributed to the concept, this created a considerable problem. Should I still use the term in all documentation sent to patients and also at the interview stage and, only in the event of there being a difficulty with it, indicate more specifically the parameters of the area of interest? Or should I present the study in more general terms and ask, for instance, about what interviewees' valued about care from their GP?

Using the term would help the speed and ease with which patients could get beyond the problem of *terminology* to focus on the *idea* of the personal in General Practice. I also considered it would support my ethical obligation to ensure patients were clear about the nature and aims of the study and what participation in it would mean for them. But, this raised the spectre of possibly having to state at the outset what the term meant to me and, thus, running the risk of 'closing down' or diverting participants from articulating their own constructions. On the other hand, depicting the study in more general terms might avert the problem of becoming stuck on the ambiguity of the term, allow me to glean data relevant to participants' constructions of personal care during this wider discussion, and avoid having to define the term at the outset while still gaining understanding of the concept by a more oblique route.

Having considered both these options, I decided that, on both practical and ethical grounds, I should use the term directly, as this was the true interest of study. However, to reduce the problem of imposing researcher-influenced notions of personal care, I added a question at the beginning of the interview guide asking for comments on whether the term meant anything. I then knew from the start whether the interviewee had difficulty with the term, and this had the benefit of opening up discussion about the terminology and the concept. I also found it useful during this early discussion, where there was uncertainty, to briefly relate examples of ways other patients had described what it meant to them in the context of General Practice. Further, I finished the interview by asking participants to reflect on whether their ideas about personal care had altered during the course of the discussions.

These approaches proved effective once interviewees had been engaged with the study and their consent to take part gained. The data obtained as a result of employing these strategies show that the *term* personal care is ambiguous and has many meanings, but the *concepts* and the dominant *discourses* drawn on underlying the label are commonly shared. Indeed, despite some people being vague at the outset about the term itself, all those who took part had a clear notion of what personal care *as a concept* means to them. Further, there were no discernible differences in the constructions produced by those who did and did not express any initial doubts about the term. This finding supports the contention that the problem of meaning has not reduced the validity of the study data. The problem of terminology and meaning will be discussed in Chapter Four. However, I speculate that using a term with little general



currency, in part, accounts for the considerable difficulties encountered during the main part of the study in recruiting some patients. These difficulties will be discussed in the next section.

## **The Main Study**

### **Practice Sampling**

A total of four practices, two small and two large, took part in the main study. Practice size was still defined by the number of doctors practising in each study site (up to three doctors constitutes a small practice and four or more a large). I concluded that selecting only two practices, one from an affluent and one from a deprived area, would leave the problem of not knowing how to account for any differences detected. Differences might be due, for example, to a variation in practice cultures. Also, even if *all* the doctors in each of only two practices took part, this would provide too small a sample of doctors. Thus, a further two additional practices (one small and one large) in total were sampled.

Furthermore, I thought that choosing one large and one small practice from each of two areas, rather than from four different areas, would reduce variability and allow a more robust examination of any relationship between practice size or deprivation score and constructions of personal care. It also permitted exploration of whether the type of care patients thought they could receive from each practice in their area influenced which practice they chose to register with. Thus, the sample gave sufficient heterogeneity to allow important comparisons to be made across two variables, but to be homogeneous enough to allow an in-



depth analysis and make any claims of variability more robust. Achieving such a balance was considered important, given the constraints of time and resources available.

The differences in the socio-economic circumstances of the two study site areas are clearly marked and have given good variability to the sample. Practice M3 is noteworthy for its unusual organizational arrangements. This is a group practice with four small practices (three single-handed and one double-handed), in the sense of having separate list systems but sharing all allied staff and administration. I have counted this as one practice when discussing total numbers involved in the study, as above. But, each one is dealt with separately as a small practice for the purposes of comparative analysis across the variables.

Thus, seventeen more doctors were recruited for interview from four practices, making a total of twenty-three doctors. Table 2 shows details of doctor numbers, practice size and deprivation score.

### **Recruitment of Practices: Practicalities and Problems**

I started by sending a letter of introduction to the senior partner of each practice requesting that the practice consider taking part in the study. A 'further information sheet' was also sent with this (see appendices D and E). Experience of recruitment problems led to my supervisors signing the approach letter in the hope of attracting more interest. Follow-up by phone occurred within one week of the letter being sent. Several difficulties in this protocol were encountered. Accessing doctors was not always easy, often taking several attempts over a

number of days before contact was made. They usually did not remember having seen the letter or had already decided unanimously that the practice would not take part. In some cases, they intended to take the request to the next practice meeting and more time was lost awaiting the result of this. I reviewed the approach and decided instead to send a letter to all doctors in the practice, with a copy to the practice manager asking her to raise it at the next practice meeting. All the doctors in each practice could then make a decision about taking part and, thus, might reduce the delay in response. The follow-up phone call was to the practice manager, who became the initial point of contact. If participation was subsequently agreed, establishing contact with her at this early stage proved invaluable for the relationship with the practice throughout the period of participation.

The new strategy was successful in reducing wasted time, but still a total of fifteen practices had to be approached (between August of 1999 and October 2000) before the four practices required were recruited. All participating practices were sent additional information about patient sampling with details of the part the practice would play in this (see appendix F). During this period, a great deal of time and effort was unproductive and gave rise to concerns I would be unable to recruit sufficient numbers of participants to the study to satisfy the study design, and would therefore have to compromise it, so lessening its usefulness, interest and validity. With perseverance, though, I succeeded in recruiting all the practices sought. The result was recruitment of an additional seventeen doctors to add to the six recruited for exploratory work, making a total of twenty-three doctors. Although it was thought possible all the

doctors from these practices might need to be interviewed, no fixed number of interviewees was pre-set at the early stage. In keeping with an inductive approach that requires flexibility and reflexivity, I decided to continue recruiting and interviewing doctors until theoretical saturation within practices had been reached (Mason, 1998).

Whilst the difficulties encountered in practice recruitment was problematic in terms of 'wasted' time and effort, the process did offer further insights into the problematic use of the term 'personal care' and the place of the concept within General Practice. A number of reasons were given by practices for not wishing to take part. Amongst those were the problems of overwork and competing demands on practices' time. For example, some stated other research requests had arrived simultaneously with my own and not all of these could be considered. Others cited excessive work demands, especially during the winter when a flu' epidemic had hit the area. Other demands on their resources included partners being on holiday, on training courses or increasingly being involved in activities outside the practice, such as the Local Primary Care Trusts.

However, interestingly, in a few cases, the doctor contacted appeared uncertain about the nature of the study topic. The term, personal care, had no immediate salience to them and, when explained, they stated that it held no interest for them. Thus, the term, whilst being more commonly used within the medical profession than by the lay community, appears still not to be universally known and used by GPs. Second, its lack of interest to some GPs indicates that not all

practitioners place value on a concept held up by so many to be the defining ideal of the profession.

Those doctors who agreed to take part explicitly stated that their reason for being involved with the study was out of their conviction this was a core value of their profession and the linchpin of their own practice. They regarded personal care as being 'the point' of doing General Practice and, so, had an immediate interest in the study area. Some explained they wished to take part due to their concern about the potential for personal care being eroded by the organizational changes in primary care that provided the impetus for this study, set out in Chapter One.

### **Patient Sampling**

As I outlined in the discussion of the preliminary work, families are the focus of the study. Families, of course, are not a homogeneous mass and I define them as households with at least one child living at home. This made the target group easily identifiable for sampling purposes. Exploratory work indicated that selecting families might produce accounts of personal care relating to the younger, middle and older generations. It had been hoped to achieve a balanced gender-mix of interviewees, but of all those who took part only four were men, and they were part of couple interviews. This was partly due to the random sampling of families resulting in over-sampling women possibly due to the fact that many in the sample were single parents and the cultural norm that women take most responsibility for child-care. Efforts to remedy this by purposively sampling more men from the lists were fruitless and, faced with the

relentless nature of the general recruitment problem, I was obliged to accept any patient fitting the family and area criteria who agreed to take part, regardless of gender. Thus, women are over-represented in this study and this should be borne in mind when interpreting the findings.

An equal number of patients were purposively sampled from each practice by only selecting from those who had a child living in the household. Each practice was asked to compile a list of all the children, aged one to ten, on the practice register. The children were then connected to their parent or caretaker by address, which overcame the problem that not all children live with one or other of their parents. Twenty potential interviewees were selected from this list at random by taking the total number on the list ( $x$ ), dividing this by twenty (the required number) and then selecting each  $x$ th person. So, if two hundred children were on the practice register, and as we were selecting twenty, each 10<sup>th</sup> child would be counted (see appendix F).

Practice doctors were asked to vet the list in order to exclude those whom they believed could be harmed by involvement in the study, but the need to include patients with a variety of circumstance and health status was emphasized. Only those known to have a serious health or other problem, potentially exacerbated by involvement in the study, were to be excluded (see appendix F). Thus, selection criteria were inclusive and not exclusive. Doctors were assured that at least three opportunities would be given to patients to refuse participation or withdraw from the study from the initial approach. In the event, no patients on any lists were excluded by doctors. Again, no firm number for patient

participants was set in advance and, in the event, fifteen more were interviewed (including three couple interviews) before saturation was reached, making a total of twenty-three patient interviewees. Table 2 shows the numbers of doctors and patients who took part in the main study by practice size, deprivation score and Health Board ranking (see appendix C for details of practices and patients).

**Table 2: Main Study Practices by Practice Size, Deprivation Score and Lothian Health Board Ranking**

Practice	No. Doctors	No. Patients	Practice Size	DepScore	Ranking
M1	3 (out of 3)	4	Small	1.3	High
M2	3 (out of 6)	4	Large	1.53	High
M3	6 (out of 6)	4	Large	-0.7	Low
M4	3 SH* 2 DH** (out of 5)	3	Small	-1.8	Low

\* SH= Single-handed                      \*\*DH= Double-handed

**Patient Recruitment and Recruitment Problems**

In three of the four practices, the list of twenty patients was compiled by the practice and given to me to pursue directly. As I outlined earlier, this strategy of access and recruitment to the sample had the purposes of securing a range of patients and distancing me from the doctors. The information contained in the list was restricted, for reasons of confidentiality, to name, address, date of birth

and a phone number, if there was one. In one case, practice M3 did not wish to hand over the list before gaining consent from each patient named on it. The practice approached the patients directly by letter, and enclosed the standard study information sheet and a different consent/refusal form to details being passed on (see Appendices H and I). The details of those showing an interest in the study had their details passed to me for follow-up.

For the three practices that gave me the sample list directly and those who had agreed to their details being passed on from practice M3, I sent out an approach letter to patients together with the standard information sheet about the study (see Appendices G and H). The latter assured patients their health care would not be affected in any way, should they decide not to take part. It further guaranteed absolute confidentiality should they decide to participate. This information sheet also included the name of an independent study advisor who could answer any questions or help them in the event of a complaint. Lastly, I enclosed a form asking the patient to sign and return it within two weeks if they did *not* want to take part (Appendix J). If I had not received a reply within the specified time, contact was made by phone or letter to arrange an appointment to give more information. Patients could, of course, decline participation on the phone or at this initial appointment, and they were advised of their right to withdraw from the study at any stage thereafter.

Thus, based on experience of having difficulty recruiting patients from areas of high socio-economic deprivation, the approach to recruitment adopted was mainly opt-out and not opt-in. I am aware that this protocol would no longer be

permitted due to subsequent changes in ethical rules governing research recruitment. Based on my experience with this study, I agree with Parry *et al.* (2001) that the new rules may have negative implications, particularly in reducing the participation of more marginalized social groups in research, as I now discuss further.

Indeed, even with this opt-out approach to the main part of the study, recruitment of patients proved to be extremely difficult. Up to four visits, numerous letters and phone calls were made to every hard-to-contact patient. However, it is important to stress that these difficulties were not universal across the sample. There was a clear distinction between the response of patients from affluent and deprived areas, regardless of the size of the practice to which the patient belonged. Table 3 shows the number of patients with whom contact was attempted before the required totals were achieved. The table also shows the number of refusals or no contacts out of the twenty patients sampled in each of the four practices. Refusal to participate, problems with ineligible addresses and lack of phones or phone numbers account for problems with patient recruitment in the deprived area. The problem of recruitment in areas of high socio-economic deprivation is well documented (Cartwright, 1983; Bowling, 1977). Refusal, non-contact and problem information have also been reported elsewhere as the cause of poor response rates in areas of deprivation (Parry *et al.*, 2001).



**Table 3: Practice Size and Deprivation Level by Patient Refusals/No contact**

Practice	Practice Size	Deprivation Score	Patient Refusals/No Contact
M1	Small	High	16
M2	Large	High	16
M3	Large	Low	4
M4	Small	Low	1

From practice M3, in the affluent area, that contacted patients directly on my behalf, seventeen patients out of the twenty approached replied and only one of them refused involvement. Thus, only three patients out of twenty did not reply. Similarly, from practice M4, also in the affluent area, only four patients had to be contacted before recruiting the three needed, with one refusal to be involved. In contrast, from practice M1 and M2, in the deprived area, twenty patients from each list had to be contacted before four were recruited to the study from each practice. This highlights the stark difference in the recruitment rates between the two areas. Put another way, out of a total of twenty-four patients approached in the affluent area, seventeen either agreed to take part or wanted more information (none of those provided with more information declined). In the deprived area, forty patients were approached before recruiting the eight needed. Most of these declined involvement with the study, either by stating this explicitly or, more passively, by repeatedly not being at home when I visited for pre-arranged appointments.

Apart from the obvious practical implications for carrying out the study, I pondered on why there should be such a stark difference in recruitment rates between affluent and deprived areas, and how such a lack of apparent interest in the study from those in the deprived area could be explained. A number of possibilities are postulated below and are based, in part, on reflections contained in my field-notes and, in part, on the data from those who did participate, especially those arising from my initial question about the interviewees' understanding of personal care.

In short, as the term, personal care, did not have 'common currency', and the decision had been taken to present the study quite explicitly with this focus, it is possible that any potential interest some people might have had in participating was reduced. If there was some ambiguity about, or total unfamiliarity with, the term, it seems likely this would impact negatively on engaging patients, as the topic of research would have no salience. This is particularly likely if people were already disinclined to take part in research more generally. Whilst this does not fully explain such a discrepancy between the response rates of the affluent or deprived areas, it may, along with other more contextual factors, offer a partial explanation.

Other factors that might account for this disparity are connected to socio-economic circumstances and the dominant culture of the community in more deprived areas. First, many were living in extremely impoverished conditions. Poor local environment and housing conditions, and financial and other material shortages were much in evidence. Some suffered from enduring

mental health problems and severe disability. Some were young women on their own with small children. It seemed clear that, for these people, daily life was a constant challenge for survival. Indeed, during the fieldwork phase, I made frequent trips to the area. Just being there and making contact with local people had a considerable impact on me. I was dismayed at seeing at first hand the conditions of their lives. It left me with a distinct sense of incongruity between the reality of their lives and the reason for my contact with them: I mean the gulf that existed between the harshness and deprivation of their daily experience of living and an academic study about the 'concept of personal care' for a stranger's Ph.D. In the end, I wondered less why I had such problems with recruitment and more how I could have expected anyone living in such circumstances to have the interest, energy or time to take part in such a piece of research. Indeed, Parry *et al.* report that:

*'... the reason most often given by those who declined to take part in the survey was that it was a low priority in their lives'*  
(Parry *et al.*, 2001: 14).

This seems especially poignant, given that, for many, the *term* personal care (not necessarily the concept or experience) may have had neither meaning nor relevance.

My experience of being in the area during the fieldwork phase made me further realise there was a distinct clash of cultures between that of my prospective interviewees and my own research context. This may have manifested itself as an issue of trust. I was someone who might be regarded as coming from 'the authorities' - a researcher from an institution of learning wanting to know about

their health care, and given the socio-economic circumstances of their lives, it would not be altogether surprising if there was an immediate barrier to them trusting me or my motives. In retrospect, having someone from within the community to introduce me, who was known and trusted (but not a doctor), may have been advantageous.

Further, my approach of contacting patients by letter on official university writing paper, followed by a phone-call to those who had one, may have been problematic. About half of those in the deprived area did not have a phone and I was obliged to rely purely on written communication. I now believe this 'official-style' approach was contrary to the culture of many of these people experiencing such socio-economic difficulties. This latter point is supported by my field-notes. I noted that, when I actually managed to make contact, I often distanced myself from the position of authority figure representing the establishment (medicine), and presented as someone concerned to ensure doctors were providing quality care and emphasizing patients' right to express opinions on that care. This was, at some level, quite unconscious and it was only upon reflection I became aware of what I was doing and was able to bring some understanding to it.

Last, as suggested by Parry *et al.* (2001), it is possible that addresses were being maintained as 'giro-drops' and this may explain why, on so many occasions, nobody was at home upon visiting. They also suggest unusual work patterns and fear of opening the door to apparent strangers, especially in high-rise

blocks, may help account for why recruitment rates were relatively low in this area.

### **Limitations of the Study**

The limitations of this study are considered to lie largely in the early approach to recruitment and in the overall sampling, and to be reflected in the recruitment problems encountered. First, early recruits to the study were made up of doctors, who were known to my department and perhaps more likely to have a commitment to a way of working in General Practice that encompassed the notion of the personal in care. Similarly, the early patients were hand-picked by those doctors. Thus, those interviewed at this stage represented a small, highly-selected group of doctors who, largely, had a commitment to, and interest in, the topic of research, and also perhaps their 'favourite' patients, many of whom confessed to involvement out of loyalty to their GP and who offered few negative comments about primary care.

Clearly, all research samples are self-selected, but the particularly high degree of selectivity in this study is also highlighted by the significant recruitment problems faced. In the case of the doctors' sample, recruitment was made difficult by a number of reported factors, including the lack of salience of the term, personal care, and the nature of the topic. Thus, the doctors who agreed to be recruited were likely to have become involved out of their commitment to this approach and, as such, they may not be representative of the profession overall. This needs to be borne in mind when interpreting how generalizable the findings based on all doctors' data and on the early patients' data may be.

It should be noted, however, that the problem of the doctors' group being highly self-selected does not apply to the larger patient sample. Although the first few patients interviewed for the early work appear to have taken part largely out of loyalty to their doctor, this was not the case for the remainder. As most of the later patients did not identify with the term, personal care, but still gave consent to be involved, it cannot be the case that they did so out of holding a particularly strong opinion on or desire for such care. Further, it is noteworthy that the data from the early and later patients show no discernible difference in content. I conclude, therefore, that the patient sample does not suffer from the same problem of selectivity. Moreover, the striking similarities between patients' and doctors' accounts may mitigate the problem of selectivity in the doctor group.

Second, as the sample is drawn from parents with at least one child up to ten years old, most patient participants are aged twenty to fifty years old. Whilst many of the accounts discuss children, and in a few instances older people, the data only report directly on this age group and, so, may not be generalizable to other age groups. Similarly, women are overly-represented in the sample due to recruitment problems, the high number of single-parent families who took part and the tendency for women to undertake most child-care. Further, the sample contains an equal number of patients from affluent and deprived areas.

However, in a few cases, patients' individual circumstances did not reflect the affluent or deprived categorization of their practice area. To remedy this, I took account not only of the practice deprivation score but the patient's reported

circumstances when carrying out the Framework Analysis. It is to the management and analysis of the data I now turn.

## **Data Management and Analysis**

### **Introduction**

In this section, I outline the approach taken, first, to gathering and managing the study data and, second, to how the analysis was carried out. I wish to emphasize, though, that this ordering is for ease of presentation only and does not reflect the approach taken in which these activities mainly occurred simultaneously. Indeed, they were not treated as separate or discrete phases of developing the conceptual work. Data analysis was begun early in the gathering phase, was an integrated part of managing the data and continued throughout the life of the study. Insights gained from ongoing analysis were used to develop data gathering and influenced how it was managed. The approach taken is typical of qualitative research, and is fundamentally based on an iterative process, as will become evident from the description of each activity as follows.

### **Data Gathering and Management**

Each interview was tape-recorded, with interviewees' prior permission. An information sheet of basic household details was completed for every participant at the end of the interviews (see Appendix L). Immediately following interviews, I listened to the tapes and made field-notes about

observations of the experience generally and points of substantive interest. Tapes were transcribed verbatim, the transcripts checked for errors against a second listening, amended, and new insights added to the field-notes. Wherever possible, this was done prior to the next interview, and in the case of the patients who were interviewed twice, always prior to their second interview. This ensured any issues or conceptual themes arising from one interview were developed in the next and specific links made between first and second interviews, where applicable. A fuller page-by-page summary of transcripts was then compiled and added to the field-notes. This aided sensitivity to the recurring themes identified and was useful in providing a summary of data relating to each overall research question. A list of key words and ideas was made at the end of this process to facilitate thinking at a more conceptual level. In this way, new, emergent themes and relationships could be considered whilst still directly tackling the pre-set research questions.

After approximately five or six interviews, I began to consider possible indexing categories. The early categories were assessed in subsequent interviews for relevance and amended accordingly. As a further quality check of the indexing scheme, each of my supervisors independently read a number of transcripts. Much discussion and some negotiation produced the indexing scheme I used for analysis (see appendix M). Subjecting the proposed scheme to scrutiny as an internal reliability check was not an attempt to obtain consensus on the scheme, but in order to ensure I had captured as much of the richness and complexity of the data as possible (Armstrong *et al.*, 1997; Seale, 1999). As Seale puts it:



*'Even if we do not finally adjudicate between competing accounts, it helps to see a little more of the accounts that are kept relatively silent in a text, and this is the function served by reporting the results of reliability and replication exercises. Internal reliability, then, refers to the extent to which different researchers identify similar constructs' (Seale, 1999: 42).*

When comfortable with the scheme, I started more structured data management by indexing the data to the category scheme. I did this, at first, by indexing each transcript to only one category. On becoming more familiar with the data, and to speed up the process, I began to index each interview in turn to all the categories. Clearly, this was not a process only of data management. Creating the categorization framework is itself a core component of the analytic work. Making decisions about the significance of pieces of data in order to place them in a category involves careful analytic thought.

Staying with the practicalities of data management, I now briefly describe the use of NVivo in the process of data management. All the transcribed interviews were input to NVivo, as were the field-notes, summaries of transcripts and other notes of a more analytic nature. In this way, all data and other writings on the study were kept together in a single location. So, NVivo was used, first, as an efficient database that facilitated easy movement within and between the data and the ideas being developed about them. Second, the automated coding facility in NVivo provided a quick way of indexing data to give a workable structure for description and analysis. Anxious to ensure this process did not become mechanistic and lead me to a structure that was constraining and reductionist, I only used the free node facility and did not create node trees. I

used more traditional paper-based methods on the categorized data in order to consider their significance in context, explore sub-themes and relationships within the thematic analysis, and the relationships across the whole data-set. However, NVivo proved to be an invaluable tool in managing the mass of data obtained from sixty-one interviews, lasting from thirty minutes to two hours in length, and in setting a workable structure for the thematic analysis.

## Data Analysis

Before discussing the detail of how the thematic analysis was carried out, and how I sought to ensure rigour and quality in this process, I first consider the way in which the epistemological status I have attributed to interview data, discussed above, has influenced my interpretation of them.

As I stated earlier, I see interview data as both representational and as constitutional of the world. Thus, when analyzing the data, I attended to both the *particulars* of what was said and the *practices* of the talk. To exemplify this, a strong theme running through interviewee accounts was the relationship between personal care and the establishment and maintenance of a moral patient identity. Indeed, a discourse of moral identity is heavily drawn upon by patients and suffused the study data. Patients' concern to construct their moral identity to me was evident in the *particulars* of the talk. For instance, discussion of how personal care, defined as seeing the known doctor, means the patient's problem would be taken seriously because the doctor knows the patient as 'trustworthy' and 'legitimate'. It was also evident in the *practices* of the talk. For example, the use of the rhetorical device of comparing themselves to others who

were deemed rather less scrupulous, labelled as 'hypochondriacs' and 'abusive' in order to distance themselves from this group and enhance their own moral status. Thus, attending to both aspects of interviewees' accounts, as Silverman (1995) suggests, has lent strength to the analysis that personal care is related to management of a moral patient identity in a morally suffused health care context, and this will be fully discussed in the findings chapters.

Managing data in NVivo, as described above, started to create a structure around the mass of data generated by the interviews in a way that ensured 'rigour' and 'integrity'. However, the closer, more detailed conceptual work was continued with traditional paper-based methods. Moving away from technological methods was due to my idiosyncratic preference to work on paper. I preferred to be able to see more than one transcript or data category at the same time and could shuffle more easily between them. It also had the practical advantage of not restricting me to working only where NVivo was available.

I started with the theme I felt was most significant in the data and was central to my research questions; those data categorized under the heading of 'knowing' (see appendix M). This theme emerged from questions about what personal care means to interviewees. It had a strong presence in both patients' and doctors' data and was identified early on as important, although the centrality and nature of this did not become clear until much later.

Briefly, in keeping with standard qualitative research analysis, I read and re-read the data placed in each category and marked by hand the recurrent or other interesting sub-themes, giving each a label. In order to understand the significance of each piece of data in some context, I bore in mind both the overall interview and other information about the person when placing interpretation on them. These sub-categories were then copied into separate folders and became the basis of the descriptive analysis and write-up. I found these methods of data management and analysis not only useful in working in a systematic way, but also in providing a good quality check. They ensured the analysis was being done 'bottom-up' and, so, the findings were grounded in the data to the greatest extent possible.

I do not claim, however, that my findings have entirely *emerged* from the data. Clearly, my own biography and pre-conceptions have influenced not only the data that have been gathered, but also the way their meaning has been constructed through analysis. I have tried to be reflective at every stage of the analytic process and to ensure that I have subjected my claims to possible revision. Two of the quality checks have already been mentioned; subjecting the proposed scheme to internal scrutiny and noting the detail of the process and context of data gathering and analysis in order to understand and review what the emerging themes are, how they connect to one another and what part context plays in them. The other main quality check was, generally, to have taken a fallibilistic approach, and used the constant comparative method, in particular (Seale, 1999; Mason, 1996). I have moved back and forwards between data and emerging concepts to try to avoid the danger of using extracts to

present and support preconceived beliefs. I have systematically searched for negative instances, by which I mean unusual or deviant cases, to review my thinking. This has had the effect of debunking, revising, and, sometimes, strengthening the analysis.

Having completed the thematic analysis of the data, I began to explore whether there were any associations between the pre-set themes of meaning and importance or value and the two variables built into the study design of practice size and the socio-economic circumstances of the practice areas. I also used this analysis to explore any new relationships that were potentially of interest as they arose during the study. I used a simplified version of Framework Analysis (Ritchie & Spencer, 1994) to explore these relationships. Framework Analysis is commonly used by applied researchers to '*facilitate systematic analysis within the demands and constraints of applied policy research...*' (Ritchie & Spencer, 1994: 176). It enables thematic findings to be mapped to the research questions and for comparison across study groups.

I adapted this method for my own purposes using it in conjunction with, and as a supplement to, the thematic analysis already carried out. I gathered together the summaries of the ways interviewees had conceptualized the meaning, importance and value of personal care. By charting these against the variables of practice size and socio-economic circumstance, the proposed relationships were explored in a systematic and thorough, but speedy way. Similarly, new relationships that were not previously contemplated, but had emerged from working with the data, were gathered and examined by this method. Further, in

keeping with good research practice as accountable and transparent, relevant interviewee details of these variables have been included in Appendix C in order to demonstrate these relationships. The findings of these analyses are presented in the following three findings chapters.

# CHAPTER FOUR

## The Meaning of Personal Care

*“‘There’s glory for you!’ ‘I don’t know what you mean by glory’, Alice said. ‘I meant there’s a knock-down argument for you!’ ‘But, glory doesn’t mean a nice knock-down argument’, Alice objected. ‘When I use a word’, Humpty Dumpty said in a rather scornful tone, ‘it means just what I choose it to mean—neither more or less’” (Lewis Carroll, *Through the Looking Glass*, 1984: 274).*

### Introduction

This chapter tackles the first research question; *how do patients and doctors construct the meaning of personal care in General Practice?* It looks at the ways patients and doctors talked about the meaning of personal care in the context of the research interviews. Most of the data presented in this chapter were elicited through direct questioning about what personal care means, as well as what it does *not* mean in order to help delineate interviewees understanding of the concept.

As I discussed in the last chapter, the concept of personal care has no *a priori* meaning and little common currency amongst interviewees. This raised particular methodological difficulties that I reconsider here, as these form the background to the discussion of the findings which follow.

Patients constructed the meaning of personal care in three ways. I have categorized these as: *personal consultation style*, which relates to the doctor's manner and attitude within each medical encounter; *whole practice care*, which relates to care provided by the whole practice; and *relational continuity*, which relates to the care occurring within the context of a patient-doctor relationship built over time. *Relational continuity* was the most significant category of meaning to emerge from these data. However, these categorizations of meaning do not stand alone. They are related in a way that highlights the complexity the concept held for interviewees.

Doctors' constructions of personal care were strikingly similar to those of patients, with only a few differences in emphasis noted. The comparison of these similarities and differences are discussed at the end of each main section. The way in which patients and doctors discussed the meaning of personal care varied systematically in one respect, depending on practice size. However, no variation was found in relation to the deprivation score of the practice area.

The ways in which patients and doctors constructed personal care in this study bear a close resemblance to the stated core values of General Practice as a profession, and to conceptualizations of such care in empirical research (Balint, 1964; Henbest and Stewart, 1990; Howie *et al.*, 1992; Hjortdahl and Learum, 1992; Freeman and Richards, 1994). This is perhaps unsurprising, given that GPs have been trained and professionalized in this ethos and claim personal care as the profession's specialism, which offers them a particular occupational identity. However, intriguingly, patients equally adopted this perspective and



rhetoric. Definitions of what constitutes the personal component in care have rarely been empirically-derived, arising instead mainly from researchers who are often doctors. The single exception to this is the recent empirical work of Preston *et al.* (2001), which explores the meaning and importance of personal care to patients and service providers, and, in the light of which, the findings of these study data are discussed.

## **The Problem of Meaning**

I described in the methodology chapter that preliminary interviews suggested that, whilst the term 'personal care' had currency with many, though not all, of the doctors who took part, it had little or no immediate salience to most patients. To overcome this problem, as a matter of course I asked both patients and doctors at the outset of the interview whether the term, personal care, means anything to them:

*RA: 'You were... saying, just before we put the tape recorder on, that you weren't terribly sure about this idea of personal care... when you first got the letter [about the study] through?'*

*Mr. George: 'Well, aye, I dealt with the letter, and, eh, I've got different opinions about what personal care is... who or what should be providing that personal care. Em, like getting personal care from your doctor, at what sort of level does that mean...? So, I wasn't too sure in that aspect what you meant by personal care' (Mr. George, MP 02-03).*

Similarly, the following extract from Dr. Franks makes the same point, although as stated, this is less common in doctors' data than patients':

RA: *'So, when you were... first approached... about being involved in this... did you have any initial thoughts or feelings about it as a research topic?'*

Dr. Franks: *'I can remember thinking, "What's this personal care?" ...Well, at first, I had no idea what personal care was, do doctors wash every day, sort of thing? I thought it was personal care of myself, not personal care of my patients, but I didn't really understand what you were getting at and, so, I had to go away and think about it...'* (Dr. Franks, MD 02-03).

Starting the interview with this open question that acknowledged the problem of terminology usually enabled interviewees to engage in unfettered discussion of the meaning that lay behind the term:

RA: *'So, when you saw the title of it [the study] looking at the idea of personal care, did that immediately mean something to you?'*

Mrs. Mooney: *'I'm not sure what it's meant to mean. To me personally, what did it mean? I think personal contact, if you have a family doctor, I think to keep the continuity of it is good and personal attention... They give it a priority, em, I think the whole, that whole thing makes GPs more accessible and approachable. Em, you know, you don't feel you are bothering them with something that's trivial. Em, so, I think, that's what I think is personal care'* (Mrs. Mooney, MP 04-01).

Indeed, as Mrs. Mooney demonstrates well, interviewees talked spontaneously about what the concept of personal care means to them once they had overcome the initial difficulty of a lack of common understanding and use of the term. The data suggest the concept has resonance to them. Questions about what the

concept does *not* mean to interviewees also proved helpful in elucidating how interviewees constructed its meaning, and several examples of such data are given in the next section. There are no discernible differences in the constructions produced by those who did and did not express any initial doubts about the term. The reason why asking what personal care does *not* mean to interviewees should be helpful is fully discussed at end of this chapter, as is the possible reason why no differences in accounts were identified once beyond the initial problem of terminology.

## **Personal Care as Personal Consultation Style**

In discussing the meaning of personal care, patients often talked about doctors' manner and behaviour during each consultation. I have categorized this as *personal consultation style*. Generally, patients associated this element of personal care as with being dealt with in a humane, respectful and individualized way in every encounter, regardless of whether or not they had previously met the doctor. This included patients talking about not being summarily dismissed and the problem being taken seriously by the doctor. For example, when asked to give an example of a time when she had *not* received what she thought of as personal care, Mrs. Peters responded:

Mrs. Peters: '*... my son took ill with epilepsy... he had that first one... through the day and went on to have another two that evening, and I was really distraught, you know, really frantic, and he [the doctor] came out and said, "Well, it's only a fit", and I was saying, "Well, you know, there's something wrong, this isn't the normal pattern for David, there's got to be something wrong here..."*. But, in the end, it was a case that

*my son is going into hospital because there is something wrong, but he was like, "Well, it's just a fit"...'* (Mrs. Peters, PP 02-01).

Other such examples include patients talking about *'not being fobbed off'* (Mrs. Douglas, MP 01-04) and *'not being pooh-poohed'* (Mrs. Thomson, PP 01-01), of *'being believed [that something really is wrong]'* (Ms. Forrest, MP 02-02) and the doctor not *'tossing you out'* (Mrs. Brown, MP 01-02). Related to being taken seriously was the feeling the doctor took time to listen fully to the patient's story and would not hurry her out of the surgery. For example:

Mrs. Smith: *'He listens to you. I feel he doesn't rush you out the surgery. I know people are only in five or ten minute slots, ten minutes if you're lucky. I mean like that time I went to see him about my mum, he didn't know what I was going to see him about, I had just been put in for a normal session with the doctor, but I ended up there quite a long time. But, he was in no hurry to throw me out, type of thing, no looking at his watch thinking, "I've got other patients I'm waiting to see", he's very good actually, very good indeed'* (Mrs. Smith, PP 02-04).

Patients' accounts suggest that *personal consultation style* incorporated the patient being given the opportunity to be totally involved in the encounter. This included being able to tell their whole story, to give a full account of their symptoms and to ask questions:

RA: *'So, say with Dr. Strong or Dr. Roberts, what do you think it is in particular that they do... that means that they are giving you the opportunity to have personal doctoring?'*

Mrs. Thomson: *'I think they're approachable, I think that's very important and they listen to you, you know... that's something that they allow you, and they also allow you to ask questions if you want to, which is not always the case'* (Mrs. Thomson, PP 01-01).

Similarly, being involved in the encounter meant having the diagnosis and treatment fully explained by the doctor and this was also identified as having the effect of making care within the consultation seem personal:

RA: *'So, can you tell me more about the contact that you would have or that you have had with Dr. Neill... what he has done or said that has made you feel that you have been getting personal care?'*

Mrs. Mooney: *'Well, his whole style, I suppose. I think he, em, he explains everything... And he, em, everything he does, whether he is taking your blood pressure, he explains why he is doing it, what he is going to do, why he is doing it and that everything is alright or if it's not'* (Mrs. Mooney, MP 04-01).

As indicated by Mrs. Mooney, patients often made reference to the doctor's *'whole style'*. The doctor's general manner towards the patient in the sense of not being *'patronising'* or *'intimidating'*, of being respectful and, generally, treating the patient humanely were regularly cited as essential features of the doctor having a *personal consultation style*. In an interview with a couple, for example, both parties agreed about this:

Mr. George: *'Because they actually, like use your names, it's the way they speak to you as well, it's not like they're...'*

Ms. Grange: *'They're not rushing you all the time'*.

Mr. George: *'They're not snapping their fingers'* (Mr. George and Ms. Grange, MP 02-03).

Other examples included the doctor having a *'nice manner'* and this was linked to him being *'softly spoken'* (Ms. Jackson, MP 03-02). Another patient referred to doctors within an individual consultation not making the patient *'... frightened of them'* (Mrs. Watson, PP 02-04), whilst one woman referred to the doctor not having a *'stern manner'* (Ms. Hamilton, MP 02-04) and another to the doctor being *'approachable'* (Mrs. Thomson, PP 01-01). Yet another spoke about the doctor treating her *'like an intelligent person and not [being] patronising'* (Mrs. Mooney, MP 04-01).

Patients talked about the doctor showing they had a *'genuine'* interest in and concern for them within the context of a consultation. For example, when asked to describe how the doctor gave personal care to her, Mrs. Anderson stated:

Mrs. Anderson: *'Em, you felt that he was interested. A lot of doctors you don't feel are really, like, "Oh God, another one, a sore throat, sore ear". But, I don't know, it's just the way he put himself across, you felt that he was interested in what you were saying, he wasn't, like, clock watching. And with John [her son], you could see he was genuinely concerned about John. You could see that'* (Mrs. Anderson, MP 01-01).

In telling me about a time she had not received personal care, Mrs. Watson made the same point that the doctor being genuinely interested in and concerned about the patient's problem is an essential aspect of having a *personal consultation style*. When talking about not receiving personal care at a hospital

appointment, and comparing this to the care provided at her own practice, she commented:

Mrs. Watson: *'I felt as though they weren't concentrating on me. He left the room to go and see somebody else or do something else. He wasn't... there one hundred per cent for me... if you have an appointment [at the general practice], from the minute you're there, the doctor is there for you... so, yes, he wasn't concentrating on my problem and, therefore, that belittles my problem. It belittled what I was there about'* (Mrs. Watson, PP 02-04).

Related to doctors showing an interest in and concern for the patient in a consultation, patients also talked about the doctor treating the patient as an individual human being and as being valued as such:

Mrs. Inch: *'I suppose it's partly to do with being recognized, and sort of valued, I don't know, if valued as a patient is the right term, but just, yes, you do, they're not just treating me like another person on the conveyor belt, "Oh, what do you want today" and "Here's this", and out the door and they've forgotten about you, onto the next one, there is a sense of, yes, being valued'* (Mrs. Inch, MP 03-01).

Others talked similarly about the doctor seeing the patient as a unique person, as *'an individual in [her] own right'* (Mrs. Ewan, MP 02-01) and not as a *'piece of meat on a slab'* (Mrs. Quinton, PP 02-02) or just *'another patient on a conveyor belt'* (Ms. Jones, MP 03-03) and as the doctor giving *'personal attention'* (Mrs. Douglas, MP 01-04).

*Personal consultation style* also incorporated the doctor engaging in general 'chit-chat' in the consultation and asking about more peripheral aspects of the patient's life. This was regarded as showing the doctor's 'appropriate' interest in the patient as an individual. For instance, Mrs. Richardson commented that her two daughters liked the family doctor from whom she had already stated she and her family receive personal care. When asked why, she replied:

Mrs. Richardson: *'She talks to them about school and everything... it is a basic interest in what they are doing or when the big one is off to High School... it's not like you're going in there and you are just a number, 'cause it's not like that'* (Mrs. Richardson, PP 02-03).

Indeed, the doctor asking for information during the encounter and holding information beyond the strictly medical, from case-notes, through contact with other family members, and with the patient in a single or over a series of consultations, was perceived to be legitimate and, sometimes, necessary to personal care. Indeed, this constituted an important aspect of *personal consultation style* as one way patients talked about personal care. Having such information was articulated as allowing the doctor to see the patient as a '*whole person*', whose wider concerns and life context were of salience to the consultation and the treatment given:

RA: *'So, you've mentioned 'whole person' and you've mentioned 'context'... what [do] you think the connection is between the whole context and personal care?'*

Mrs. Jackson: *'Obviously, it's got to be put in context. It's, em, your background, your family set-up and family history and marital status, that will have a bearing on your various*



*illnesses and treatments and for the treatment, for something to be relevant, your background could be relevant for treatment given'* (Mrs. Jackson, MP 03-02).

Being known by the doctor as an individual person was central to patients' descriptions of what constitutes personal care across all the categories of meaning and will be more fully dealt with in the next chapter which is dedicated mainly to discussing the important theme of 'knowing'.

Finally, in giving examples of personal care in the context of each consultation, patients regularly made reference to the significance of the doctor's body language, which was seen as important in relaying to the patient the doctor's interest, care and respect. For example:

Mr. Uphall: *'... Dr. Roberts is particularly good in my opinion... he listens, and therefore we're happy there and we'll keep going... I'm quite impressed with Dr. Roberts, because he will look at you and he doesn't start writing until you finish your conversation. There is nothing more annoying than you talking to someone and them starting writing down...'*

Mrs. Uphall: *'But, they [those who don't give personal care] start writing a prescription before you've told them fully what your symptoms are...'* (Mr. and Mrs. Uphall, PP 01-02).

Indeed, one patient talked explicitly about the importance of body language, using these precise terms:

RA: *'So, what is it she does that makes you feel that she's giving you personal care?'*

Mrs. Richardson: *'She's just very calm and she'll turn her chair and she'll just sit and listen, basically it's body language, because I mean some of them just sit there and write a prescription out...'* (Mrs. Richardson, PP 02-03).

The above two extracts provide good examples of recurrent data that were present in most accounts of this category of patients' construction of personal care. I have called these data 'prescription stories'. All shared the same features and appeared to serve the same purpose. They displayed what personal care was not. It was not being dismissed and having the problem taken lightly. It was not being given sufficient time and encouragement to fully tell the doctor about the symptoms of illness or the overall problem. It was not, in consequence, being given a diagnosis and treatment that would be unlikely to resolve the problem, as the doctor would fail to *'get to the root of the problem'* (Mrs. Brown, MP 01-02). These prescription stories provide negative descriptions that support the other data already presented, which illustrate how personal care as *personal consultation style* was constructed.

Thus, one of the foci of how personal care was constructed in interviews with patients was doctors' manner, attitude and behaviour within each consultation. This included what doctors said, how they said it, their non-verbal communication and the space that was made available to patients to fully participate in the consultation. These data also reveal the extent to which, for patients, the meaning of personal care was bound up with the *experience* of care and not just with medical outcomes. Doctors spoke in similar ways about *personal consultation style*, and it is to this I now turn.

## The Similarities and Differences between Patients' and Doctors' Accounts of Personal Consultation Style

Doctors also talked about the meaning of personal care in relation to their *personal consultation style*. Like patients, they were referring to care when given either to a known or previously unknown patient in the context of each medical encounter. Their manner, attitude and behaviour toward the patient in that encounter were described as being pivotal to the provision of such care. That consultation style was also central to doctors' construction of meaning is exemplified by Dr. Gilmour, who is referring here to giving personal care in every consultation:

RA: *'Patients have said different things to me [about what personal care means] when I did the piloting, and doctors have said different things'.*

Dr. Gilmour: *'Well, yes, that's interesting that doctors should see it differently... I can't see any other definition than the idea that you're, em, inclusive and receptive... and empathetic...'* (Dr. Gilmour, MD 03-01).

Dr. Gilmour also illustrates some of the specific features that GPs recurrently attributed to this category of meaning. In parallel with patients' accounts, these aspects included the doctor taking time in the consultation to listen to the patient's complaint or problem, not rushing the patient out of the surgery, and fully explaining the cause of symptoms and proposed treatment. Such a consultation style was expressed as an important ideal of personal patient care, despite high service demand and time constraints. It was deemed an essential component of giving personal care to all patients, and as allowing patients to

'open-up' to the doctor. Dr. Abraham demonstrated this point by stating first what he considers does not constitute personal care:

RA: *'You've told me quite a lot about what you think personal care is... and I just wondered if you could tell me... what you think is not giving personal care?'*

Dr. Abraham: *'... often people get to the end of consultations and discuss something that is very important to them and... a number of doctors have said, "It'll be alright, off you go, come back and see me about that", and I don't think that's very good personal care... for example, you say, "How are your parents getting on?", and they burst into tears and say, "My father's just found out he's got lung cancer", and you say, "Well, that's right, we'll see you in a month and do your blood pressure" (Dr. Abraham, MD 01-01).*

In contrast, he described what personal care within each consultation is:

Dr. Abraham: *'I think personal care is two, I mean has two aspects. First of all, one is the fact that you are genuinely interested in that person as a person, and whether or not they are ill is important to you...'*

RA: *'How do you convey that to the patient... that you are interested in them...?'*

Dr. Abraham: *'I think it's just in terms of being friendly and helpful, em, and trying to provide advice and support...'* (Dr. Abraham, MD 01-01).

In addition, as Dr. Abraham shows, taking a 'genuine interest' in the patient was commonly ascribed by doctors to this category of personal care. So was the doctor having a sense of responsibility and commitment towards the patient

within each encounter, which should be clearly demonstrated during the consultation:

Dr. Neill: *'For those ten minutes they should be the most important person, or they should feel that they are the only person that matters to you as the doctor... I suppose that goes for any consultation... for that length of time nothing else matters except that person and their problem'* (Dr. Neill, MD 04-02).

Doctors spoke recurrently about their approach to the patient in terms such as being *'friendly'* (PD 01-02), *'empathetic'*, *'approachable'* and *'receptive'* (MD 01-02), *'respectful'* (MD 03-02), *'humane'* (MD 02-01), and *'courteous'* (MD 04-03). Indeed, resonating with patients' data, doctors' communication skills and body language were central to doctors' descriptions of such care within each encounter. Doctors also placed much emphasis on working in an *'inclusive way'* (Dr. Neill, MD 04-02) with the patient, meaning the approach taken was one in which patient and doctor work together in *'partnership'*. *'Negotiation'* and *'mutuality'* were stated to be core principles of the doctor's practice in this respect (Dr. Clarke MD 01-03 and Dr. Roberts PD 01-01, respectively). Although expressed in different terms, this is paralleled in patients' talk of being treated as an equal, with respect, like *'an intelligent person'* and as *'not being patronized'* (Mrs. Mooney, MP 04-01), and the consultation being generally participative in nature. The emphasis placed by doctors on treating the patient as an equal and with respect and on encouraging them to fully participate in the encounter is summarized by Dr. Wilson when asked:

RA: *What would you say isn't giving personal care...?'*

Dr. Wilson: *'Ignoring their agenda, dealing with only the technical side, not the personal, the emotional side, making presuppositions about them, I mean, labelling them, for instance, failing to negotiate. I think, like I said before, failing to develop any mutual respect or empathy, whatever that might be. It doesn't have to be affection. I mean, ideally, there should be an element of affection, but some sort of respect of the situation they're in and how they're dealing with it'* (Dr. Wilson, PD 03-01).

Like patients, doctors also commented that engaging with patients in social conversation about matters beyond the medical complaint at hand is an important aspect of their behaviour in every consultation:

Dr. Kerry: *'So, you may find that part of the consultation has got nothing to do with the presenting problems or matters in hand'* (Dr. Kerry, MD 03-05).

Similarly, Dr. O'Reilly made the same point about the importance of this sort of engagement in what he considers to be personal care in every consultation:

Dr. O'Reilly: *'... you have a wee chat about how the person's been, how's the dog, how's the wife, how the weather is? ... really just the type of stuff which is the lubrication jelly, really. We both know that we're just saying something like, "You're human, I'm human, and we're OK"..."'* (Dr. O'Reilly, MD 04-03).

Related to the emphasis on having discussion which goes beyond the 'presenting' medical problem, doctors constructed personal consultation style as being characterized by dealing with the whole person. That is, as being

concerned about the wider context of the patient's illness and life experience in every consultation whether the doctor knows the patient or not:

Dr. Franks: '*... I think it's a very natural part of General Practice. I think you've got to look at the whole picture, you know, a patient comes with one problem... it's quite nice to see the whole person... then, you can see why they are worried about something...*' (Dr. Franks, MD 02-03).

Dr. Franks exemplifies how *personal consultation style* was commonly expressed as being concerned with seeing the patient as an individual, whose life context may be relevant to their ill-health and whose wider concerns should be taken account of in every encounter. Having such information was typically described as allowing the doctor to attend to the patient's needs beyond the physical, as will be further discussed in Chapter Six, and was recurrently referred to as '*whole person care*' or '*holism*'.

Thus, like patients' accounts, doctors stated that their manner, attitude and behaviour, specifically their communication skills and body language, were important facets of giving personal care in relation to *personal consultation style*. Indeed, for both patients and doctors, engaging in chit-chat was expressed as indicating the doctor was taking an interest in them as individuals. It appears to have a relationship building and cementing function, as indicated by Dr. O'Reilly, above. Related to the emphasis on having discussion which goes beyond the 'presenting' medical problem, doctors constructed *personal consultation style* as characterized by care that deals with the whole person; as being concerned about the wider context of the patient's illness and life experience. Again, such wider information could be gleaned from asking

questions in the one-off encounter with, or from the case-notes of, an unknown patient or through previous experience of a known patient or her family. In addition, it was thought to allow for individualization of care; care that is tailored to the individual needs of the patient, another facet of this element of personal care present in both patients' and doctors' accounts. These facets of doctors' construction of personal care as *personal consultation style* parallels patients' recurrent talk of being treated as an experiencing person in a wider life context for whom care was specifically tailored; as the patient being dealt with as '*an individual in [her] own right*' and not as a '*piece of meat on a slab*' (Mrs. Ewan, MD 02-01).

As these data also illustrate, doctors told their own prescription stories. *Personal consultation style* involved the doctor getting behind the presenting problem and not over-medicalizing any complaint. Indeed, this was discussed as a major benefit of such care, and will be fully discussed in Chapter Six. Consonant with patients' accounts, doctors talked about personal care as being as much about the patient's *experience* of care and the interpersonal quality of the encounter as with the medical care provided in more technical or outcome terms.

Thus, the features attributed to this construction of personal care by doctors were largely consistent with those of patients. However, one difference was that doctors regularly talked about such care as incorporating the use of 'the self' in the encounter with the patient. For instance, in contemplating the difference between care from the out-of-hours co-operative and what he provides within his practice to either a known or unknown patient, Dr. Ibsen commented:



Dr. Ibsen: *'Well, I suppose, that's a different definition of personal care... I think, however basic the interaction is, you know, at that level it has to be personal because you have to develop some kind of rapport with the patient... yes, yes, you're giving a bit of yourself to the transaction (Dr. Ibsen, MD 03-03).*

Indeed, doctors often spoke of personal care as involving the use of personal resources beyond their technical, medical skills. Patients could hardly be expected to comment on this, but it is notable as being the one feature that distinguishes doctors' accounts from those of patients.

## **Personal Care as Whole Practice Care**

Patients also constructed the meaning of personal care in terms of what I have categorized as *whole practice care*. This way of talking about personal care is set apart from the others by focusing more on the patient's experience of the practice as a whole, rather than on an encounter or relationship with individual members of the primary care team. It encompasses being treated well by staff other than doctors. It also encompasses talk of the care being organized in a way that is perceived to meet the individual needs of the patient.

It was often described in terms of the patient's *'familiarity'* with the whole practice, including the physical environment, rather than with an individual member of staff. For example, Ms. Jones in discussing what she thinks constitutes personal care stated:

Ms. Jones: *'... I suppose a lot of it's down to familiarity, I mean, having been there for a few years, you go in, you feel you know where you are, it's not the same nervousness when you're not quite sure of the procedure in the waiting room and going through, sort of know the territory...'* (Ms. Jones, MP 03-02).

Familiarity with the whole practice was also described as having relationships with members of staff beyond individual doctors. For instance, Mrs. Thomson explained that she regards personal care as her relationship to the whole practice. In reply to my statement that the study is examining what personal care means and what value or importance it may have, she commented:

Mrs. Thomson: *'I think it's quite valuable, not necessarily a doctor [her emphasis], but a practice or people you could definitely identify with, as opposed to a large multiple practice where you may be see a different doctor every time and there's no relationship built up...'* (Mrs. Thomson, PP 01-01).

Personal care was also articulated, in this respect, as the manner and approach of all practice staff. This was most often, though not exclusively, mentioned in relation to reception staff. Similarities were identified in patients' talk about the manner and approach of staff as a group and that of the individual health care practitioner, as described in relation to *personal consultation style*:

Mrs. Uphall: *'Well, we've always had a good service... They all know us. I went in with a prescription this morning, "Oh, thank you, Mrs. Uphall" ... and it was a fairly new receptionist there... and if we ask for anything, they always, sort of, get it... if you've got any questions you can ask them... and they phone you back...'* (Mrs. Uphall, PP 01-02).

Knowing and being known by practice staff as a whole was a further feature of this way of talking about personal care. The typical inclusion of knowing in relation to the whole practice was emphasized by Ms. Vickers:

RA: *'So when you ring up, they know who you are?'*

Ms. Vickers: *'In fact, they know, before I even have to tell them who I am, I think ... and [her daughter] always goes in, and she's cheeky, and she goes behind the counter, you know, and they let her sit at the typewriter, so, that's all been quite important. It's not just the GP. It's the whole set up at the surgery... I mean, if you go somewhere, the reception staff are a bit antagonistic, that doesn't help either... sometimes getting to the GP isn't easy'* (Ms. Vickers, PP 01-03).

Again, the emphasis placed on 'knowing', also evident in the category of *personal consultation style*, will be fully discussed in Chapter Five.

Many interviewees spontaneously mentioned the poor manner of reception staff in order to exemplify what did *not* constitute personal care. For instance, Mrs. Anderson was full of praise about the personal care she receives from her own, known doctor. She then offered the opinion that the reception staff as a grouping was '*another story*':

RA: *'OK, tell me the other story'*.

Mrs. Anderson: *'Oh, the receptionists. I just can't abide the receptionists. I think it's that snotty attitude again. I don't understand why people react like that towards other people. I just don't understand it. Why they have to put that snotty, abrupt attitude on. I don't know why they are like that, if it's*

*training or... I just don't see a need for it' (Mrs. Anderson, MP 01-01).*

The second way in which *whole practice care* was articulated by patients was as the service being organized in a way they perceive meets the needs of the individual patient. For instance, it was expressed as having systems to provide follow-up care after hospital admission, the birth of a baby or, in one case, for developmental check-ups for young children. Here, Mrs. Anderson had given two examples of a time when her own doctor had provided her with personal care. She distinguished this from there being a system that enables 'follow-up':

RA: *'So is there a sense in which you felt like, with these two episodes... that you have had what you think of as personal care or not...?*

Interviewee: *'Well, yes and no. I think I did get personal care personally from Dr. Abraham himself. I think if he'd made an effort to follow-up, he doesn't follow-up, and I think that's more personal care. If they follow up on you, or even a nurse... maybe not himself. I mean doctors can't do everything, but maybe somebody. But, from him personally, yes, he did, I think he gave me personal care at the time'.*

She complained that, when her young son had returned home following an emergency admission to hospital during one of these two episodes, there was no follow-up from the practice:

Mrs. Anderson: *'I was terrified. Especially when they flung him on oxygen and put a drip in... and he [the known GP] was really good, but when he came out of hospital there was nothing, that was it' (Mrs. Anderson, MP 01-01).*

Mrs. Anderson, Mrs. Brown (MP 01-02) and Mrs. Mooney (MP 04-01), for instance, all noted that it was the policy of their respective practices for their doctors often to make a home visit following the birth of a child. They felt that this constituted good personal care, which emanated from the practice having such a systematised policy. Indeed, such systems were seen to support the doctor to provide continuity of care through the process of care or an episode of illness.

Further, *whole practice care*, in these terms, was also constructed as the way in which the service is organized to provide well co-ordinated care. It was mainly discussed as having systems in place to ensure patients moved smoothly from one health care practitioner to another and, as a part of this, the efficient transfer of information within the primary care setting. This included staff discussing patients as a team and passing written information between one another:

Mrs. Inch: *'... and you felt that they [the doctors] knew you and you felt that they communicated with the health visitor, the relationship between the health visitor and the doctor seemed very close because you didn't have to... make two separate appointments. You went in once, you saw the health visitor, you saw the doctor, you know... it seemed to be very seamless...'* (Mrs. Inch, MP 03-01).

Mr. Inch agreed with this assessment and commented that such attributes of care between the practice and hospital are also important in the provision of personal care. In reference to hospital tests and treatment, Mr. Inch commented:

Mr. Inch: *'[There have been] delays... not life-threatening... on your particular subject of customer care... if it was some*

*other doctor picking up the reins... and there's information missing, it's going to make the service less effective... you're accepting that it's pooled customer care, you'd obviously have to make sure you had a decent back-up system that collected information and made sure it was instantly available' (Mr. Inch, MP 03-01).*

Whilst patients regarded the passage of written information as having an important place in *whole practice care*, it is worthy of note that many viewed patient records as having certain limitations. In many situations, it was regarded as less desirable than being known directly by the health care provider. For instance, Mrs. Douglas, when talking about seeing a doctor from the out-of-hours service, stated she appreciated the same doctor attending her over an acute episode of appendicitis:

RA: *'And even although you knew you probably would never see her again, it was still important for you...that she was the one who saw you through that particular [unfinished sentence due to interruption]...?'*

Mrs. Douglas: *'Yes, I think so, yes. You know, when I phoned up..., I wasn't one hundred per cent sure it was her, but when she came in, I thought, "Oh, good, it's the one I saw earlier on, you know", because obviously she had seen me earlier on, she knew the sort of level of pain I was in there, I was able to walk about, I could pop on the bed for her to look at me, whereas, by the time she came out at eleven o'clock, I could hardly get out the chair and that's when she said, "I'm not even going to look, I can tell" you know, because she'd seen the difference, how I'd gone downhill, whereas, if it had been somebody different, they wouldn't have known that, you know, so it was nice in that respect and that she knew me from that night...'*

RA: *'So, even although that doctor in that situation from the first time she'd seen you might have written a few lines about what you were like and what your level of pain was, do you feel you still can't quite capture that in the notes?'*

Mrs. Douglas: *'Yes, just like the paleness of my face or just the way I was walking, you can't write that down'* (Mrs. Douglas, MP 01-04).

Patients also talked about *whole practice care* in terms of the practice having an approach and systems in place that facilitate speed of access. This was mentioned, for instance, as the receptionists slotting children in quickly, when the parent deems it necessary:

RA: *'So when you saw the title of it looking at the idea of personal care, did that immediately mean something to you?'*

Ms. Nicols: *'I'm not sure what it's meant to mean. To me personally what did it mean? ... I had one or two complications following the children where my GP, in particular, I thought was excellent and particularly in terms of coming to the house or whatever. Em, I think that most practices when there is an ill child and you phone up they do their best to try and slot them in. They give it a priority em, I think the whole, that whole thing makes GPs more accessible and approachable. Em, you know you don't feel you are bothering them with something that's trivial. Em, so I think, that's what I think is personal care'* (Ms. Nicols, MP04-02).

Other examples include the practice being organized to enable patients to obtain health care at times which suit their lifestyle, such as offering surgeries at the end of the working day. Thus, speed of access to care was not talked about by patients as distinctive to the concept of personal care, but as one element of it.

In keeping with *personal consultation style*, accounts of *whole practice care* highlight the emphasis patients placed on both the *experience* of care, as well as the more medically-oriented, systematic, organizational aspects of health care delivery, albeit from the whole practice. Again, patients' accounts of this category of meaning are paralleled by those of doctors, and I turn now to a comparison of similarities and differences.

### **The Similarities and Differences between Patients' and Doctors' Accounts of Whole Practice Care**

*Whole practice care* also featured in doctors' accounts of what constitutes personal care. As with patients, doctors expressed it, first, as relating to the manner and approach of the whole practice to the patient and, second, as the patient knowing and being known by the staff team. This was exemplified by Dr. Roberts:

RA: '*... what does personal care actually involve for you... what does that mean to you?*'

Dr. Roberts: '*... the impression they get from a practice is quite an important part of that... the receptionist, people have commented on the practice here that the receptionists have always been recognized as being friendly. People come in and they are sometimes amazed that they know their names without them having to say it. And, so, it's not just to do with me as a doctor, it's to do with the practice as a whole...'*

The patient being familiar with the practice as a whole was also encapsulated by Dr. Roberts, as he continued:



Dr. Roberts: *'... the patients feeling they belong to a practice... it's not just an impersonal place they come to... they know that they're registered with somewhere that's got a kind of personal feel about it rather than just a big impersonal organization'* (Dr. Roberts, PD 01-01).

Similarly, Dr. Emmerson talked about the importance of reception staff being friendly and helpful when dealing with patients, as part of his construction of personal care at the organizational level. He went on to comment on the importance of holding knowledge of the patient amongst practice staff more generally:

Dr. Emmerson: *'... and hence, from her [the patient's] point of view, it was important to have that knowledge, but then, in that case, personal care from the practice rather than from the individual'*.

RA: *'So, you see personal care as operating at two levels between the individual doctor and patient and also in terms of the practice staff?'*

Dr. Emmerson: *'Yes, I think you've got to, because you've got to develop personal knowledge as a team, as well as an individual...'* (Dr. Emmerson, MD 02-02).

Dr. Franks exemplifies further the recurrent incorporation of the manner of practice staff, and not just the individual doctor, in this way of talking about personal care. However, she also made explicit how this is related to the practice attending to patient needs, the second typical feature of such accounts paralleling those of patients:

RA: *'What about reception staff? Do you have any feeling about whether reception staff are involved in this [giving personal care] or not?'*

Dr. Franks: *'I think the whole practice is involved. I think reception staff are absolutely vital. The way they answer the phone... if somebody is on the verge of making an appointment and the reception staff are nasty to them... I would just put the phone down, so, I mean it's vital... I mean, they were great because they would direct people to the doctor they thought, you know, somebody phoned up and said, "Well, I want to see a woman doctor", they guided them to whoever'* (Dr. Franks, MD 02-03).

As indicated by Dr. Emmerson's account cited earlier, practice staff holding and sharing information about patients was frequently mentioned in relation to whole practice care. This aspect of *whole practice care* was mentioned by patients, but doctors placed greater emphasis on it. Doctors emphasized the practice providing a co-ordinated service to the patient, and the practice meeting the individual patient's needs, say, in the event of the known doctor not being available:

Dr. Ibsen: *'... we quite often talk about problems amongst ourselves and just asking each other's advice... a lot of the patients, although we may not see them, we know a bit about them because we discuss issues amongst ourselves... that means... if somebody's on holiday and you see a patient that's normally looked after by one of your partners often, although you may not have been really been involved with them directly, you do know a bit about them... it's not going into something blind'* (Dr. Ibsen, MD 03-03).

Like patients, doctors regarded written notes as an inferior source of information to knowing the patient personally or obtaining information from another practice member who knows the patient personally.

The GP's role as 'care co-ordinator' was suggested as another element of personal care by the whole practice. It was described as care provided by a number of staff in the primary care team or in secondary care, but where the GP has the role of 'key worker' (Dr. Harris, MD 03-02). In another example, Dr. Wilson explicitly mentioned the care co-ordination function in his definition of *whole practice care*:

RA: '*... I was interested in what you understand by that concept of personal doctoring?*'

Dr. Wilson: '*... the important things are that, from a technical point of view, that one doctor gets all the information fed back to them and what's happening with that patient, so that they can co-ordinate their care and what the drug interactions are, and so on*' (Dr. Wilson, PD 03-01).

Again like patients, doctors talked about the practice organization meeting the needs of the individual in relation to access when discussing what personal care means. *Whole practice care* incorporated the surgery having times that suit the practice population in order to aid access:

Dr. Abraham: '*... if you run on from five 'til six or later, then at least some people are getting the benefit of coming after work... so, giving a personal service may involve you in seeing patients slightly out-of-hours*' (Dr. Abraham, MD 01-01).

Thus, as paralleled in patients' accounts, personal care and accessibility were not mutually exclusive when doctors talked about *whole practice care*.

Doctors also expressed *whole practice care* as attending to the patient's individual needs by having effective systems to ensure continuity of care by the known doctor. This was most prominent in discussion about patients who were experiencing particularly serious difficulties. For instance, Dr. Neill spoke of having a policy of always visiting patients who had been admitted to hospital:

RA: *'Are there any ways, in particular, that you have organized your practice to try to support the idea of personal care?'*

Dr. Neill: *'... if I have somebody in hospital... for a bit longer than that [two or three days], I will always go and visit them in hospital... and I say, "just because you are in here doesn't mean that I'm not interested in you" ...You are showing that you are interested in that person' (Dr. Neill, MD 04-02).*

Similarly, the practice having a policy of follow-up through home visits by the known doctor after the birth of a baby, during a crisis or in the event of a death was discussed as a constituent of this category of personal care. During an interview with Dr. Ross, a practice partner interrupted to advise him that one of his patients had just died. Dr. Ross explained he had been treating this patient for cancer over many months and, during this time, had become close to the family. He explained further that it was common practice, whenever possible, to ensure the doctor with the best relationship to the family visited on these occasions. He went on:

Dr. Ross: *'I mean, that was one of the partners asking if I would go and do the death certificate. I mean, yes, I will, because I know him and I know the family, and I think they would want me to do that. I mean, she was quite happy to go and do it herself, but I think that's something that one does and, I suppose, you could put that under the heading of personal care... that kind of thing happens all the time'* (Dr. Ross, MD 03-04).

However, attending to the patient's individual needs was articulated in relation to practice organization in a way that was not mentioned by patients. It was discussed in one large practice within a deprived community as the service being organized to take account of the culture of the practice area. For instance, Dr. Emmerson summed up his view of personal care at the organizational level in this way:

Dr. Emmerson: *'... you develop a practice culture, if you like, which reflects the personalities and ideas of the people working in it, as well as the people who come to it'* (Dr. Emmerson, MD 02-02).

Likewise, Dr. Davidson, from the same practice, talked about personal care being linked to the wider social and political context of health and the need, therefore, to accommodate the needs of individuals within that community. Having problems in this interview with the tape recorder, I recorded in my field notes:

*'For example, she talks about it [organizational level care] being predominantly a working class area the practice serves. She says there is no point in having an all appointment system if most peoples' lives are inevitably chaotic and patients find it*

*difficult to keep those appointments. They run both appointment times and open surgery times. She feels, otherwise, they would be imposing middle class values and expectations on working class people'* (Field notes for Dr. Davidson, MD 02-01, 15/01/2000).

Thus, like patients, doctors constructed personal care as relating to the whole practice both in terms of service provision from staff other than an individual doctor, and as the service being organized to provide care that is experienced as personal to the individual patient and which ensures good continuity and co-ordination of care. However, one difference noted is that doctors constructed organizing services to suit the practice population or local community in cultural and socio-economic terms. This difference may arise because GPs care for people within communities. They are continually required to consider and respond to the particular characteristics of that population. However, for individual patients, this may have little or no salience. Overall, this category of meaning of personal care was given greater prominence in doctors' accounts than it was in patients, presumably because doctors have a responsibility to organize care.

## **Personal Care as Relational Continuity**

The main way in which patients talked about what personal care means to them was as, what I have called, *relational continuity*. This way of talking about personal care is characterized by the patient-doctor relationship built over time in which *mutual knowing* and *mutual trust* between patient and doctor are key features. By mutual, I do not mean the nature of the knowledge or trust referred to is equivalent, but that each party talked about knowing and being known by

the other. This is the case throughout the presentation of these data and in all discussion of the data analysis.

Illustrating that *relational continuity* was characterized as care provided by the doctor within the context of a relationship built over time, Mrs. Inch, when considering the difference between what does and does not constitute personal care, stated:

Mrs. Inch: *'The difference is that they know you. That they know you and they know your family and they know your circumstances and there is just, there is a relationship, there is already a relationship and any visit for whatever reason builds on the relationship and adds to what you know about them and what they know about you'* (Mrs. Inch, MP 03-01).

Again, patients' accounts of what does *not* constitute personal care were useful in elucidating what the concept means to them, in this respect. In the following example, Ms. Campbell compared seeing a hospital doctor to seeing her 'own' GP:

Ms. Campbell: *'It's not the same, no, it's not the same as what you get from your own doctor, although he [the hospital doctor] was a good doctor, it's not the same care as your own doctor'*.

RA: *'Right, so what's different, do you think? Can you think of what's different there?'*

Ms. Campbell: *'Well, as I said, I don't really know the person, eh, so I'm quite funny that way... I've got a good relationship [with the known GP], right enough. You can speak to them about, sometimes I can speak to them about my problems, it all depends on how you feel and that, but I must admit, I've got a*

*good relationship with my doctors'* (Ms. Campbell, MP 01-03).

*Relational continuity* was recurrently expressed as having a number of specific features. First, as the above indicate, patients talked about the relationship between patient and doctor, as well as between the patient's family and doctor. The above extracts also indicate the second feature of this way of talking about personal care; that the patient *identifies with a particular doctor*. Patients typically talked about *relational continuity* in terms of the care received from 'my doctor', the 'main doctor', the 'family doctor' and from the doctor whom they 'usually see', whether or not she is the one with whom they are registered. Indeed, the patient's identification with a particular doctor as a core element of personal care was put succinctly by Mr. George:

Mr. George: '*... seeing your own doctor is a personal service [his emphasis]*' (Mr. George, MP 02-04).

Identifying with a doctor incorporated the notion of exclusivity of care from one doctor:

RA: '*Did the idea of personal care mean anything to you when you read the letter [about the study]...?*'

Mrs. Douglas: '*Personal care, to me, personal care would be one doctor, who personally looks after me, and he would be the only one person that I would see. That's what I would take it to be. So, they would really know me*' (Mrs. Douglas, MP 01-04).



This was not only mentioned by patients from single-handed practices, where exclusivity of care is offered *de facto*, but by patients from all practice sizes. However, whilst exclusivity is a desirable aspect of such care, some thought it was not always possible due to resource constraints and logistical problems in the health service. Mrs. Douglas, cited above for instance, ended her explanation of what she thinks constitutes personal care by adding:

Mrs. Douglas: *'I can't ever see that [only being attended by one doctor] happening, because it's probably totally impractical'* (Mrs. Douglas, MP 01-04).

Mrs. Ewan stated that, although she prefers to see her 'own' doctor whenever possible, and that this is the main context from which she receives personal care, she also chooses to consult two other doctors in the practice, both of whom she knows. She went on:

Mrs. Ewan: *'So, I feel really at ease with these three doctors, so, these are the three that I've always chosen to go and see'* (Mrs. Ewan, MP 02-01).

Other reasons for patients building a relationship with a small number of health care professionals included; choosing particular doctors for certain ailments due to them having a known area of expertise, situations where patients don't care which doctor they see and those where patients make an active choice to see a previously unknown doctor. These issues will be fully dealt with in Chapters Five and Six.

*Relational continuity* further encompasses the idea of the patient being cared for and feeling cared about by the doctor. This is distinct from the doctor showing a caring attitude within each single encounter, as evident in *personal consultation style*, as temporality appears to transform it into the doctor taking responsibility for, and having a commitment to, the care of the patient and her family's health in a broader sense:

RA: '*... when I talk about... getting personal care from a doctor, does that mean anything...?*'

Mrs. Peters: '*Getting personal care, no. I think, you know, a family doctor, your doctor.*'

RA: '*... how would you describe having your own doctor, what does that actually mean to you?*'

Mrs. Peters: '*... I think the main thing is that Dr. Ure has been there for me in the past... trying to cope with epilepsy within the family, if I've needed support... I've found he's very good that way, you know, just for someone to talk to... Dr. Ure was really very good there, he helped to get you sort of through that... You need someone, it's nice to know someone is, that your GP's there... you know, that he's really interested in what's happening with you... for instance, getting my appendix out last year... he phoned when I came home, "How are you? How did you get on with your appendix", you know, "How are you doing? Is there anything I can do?" Just that somebody's, you know, your GP's there and caring about your health, you know, and concerned about your well-being, you know, it's nice to know that somebody's there...*' (Mrs. Peters, PP 02-01).

Indeed, personal care in the context of the ongoing patient-doctor relationship was associated with the doctor *'taking a special interest in you'* (Mrs. Kyle, MP 03-03).

Another feature of *relational continuity* present in these accounts is the emphasis placed on the patient being known by the doctor. Just as they had talked about familiarity with the practice as an aspect of *whole practice care*, patients also talked about being familiar with and being known by an individual doctor (or small number of health care professionals) when talking in this way about personal care and often made this quite explicit. For instance, Mrs. Kyle, in explaining what she means by the patient-doctor relationship above, also noted it involves the doctor knowing the patient:

Mrs. Kyle: *'Well, I suppose, a doctor-patient relationship would probably be when you lived in the same town all your life and the doctor knew when you were born and knew your family, knew your family history and all the rest of it, whereas, moving around and you go to a new doctor, they just see you as you are now'* (Mrs. Kyle, MP 03-03).

As demonstrated in many of the above data extracts, mutuality of knowing was also evident in patients' descriptions of what constitutes *relational continuity*; the patient is not only known by, but also knows the doctor:

RA: *'So, is there anything about those things that we've discussed... which you think of as being personal care...?'*

Mr. George: *'... I'd say seeing another doctor in the practice has been personal because you're seeing them one-to-one, but it's not as personal [as seeing your own doctor] because you*

*don't really know that doctor... and I feel, they don't really know you on a personal basis. Whereas, seeing your own doctor... you get to know him on a personal basis and they get to know you on a personal basis, and I feel they're able to get more of a personal care package' (Mr. George, MP 02-03).*

Indeed, *relational continuity* included the same reference to the patient being treated as an individual, as a whole person whose wider concerns and life context mattered, as in the above discussion of *personal consultation style*. As stated there, this is expressed as an element of personal care in the context of each individual encounter. However, it is more prominent when patients talked about having a relationship with the doctor in which *mutual knowing* is linked to the doctor's greater ability to treat the patient as an experiencing, unique human being in an individualized way.

Last, these accounts frequently include discussion by patients about the trust engendered between patient and doctor. Again, this feature of trust is mutual in nature and is common in patients' data. Comparing the care she receives from an unknown doctor to one with whom she had built a relationship and where *mutual knowing* pertains, Ms. Leishman explained:

Ms. Leishman: '*... and I actually think it would make a difference to me as well, even just taking it [the doctor's advice] on the phone, if it was one of the doctors I knew and trusted rather than a name whom I had never heard from. So, I think I would partly be less upset by one of my own doctors, one that I knew, saying that over the phone, than somebody I didn't know*'.

The mutual nature of trust is again evident in how Ms. Leishman continued with her account:

*'... but, I also think that, em, that they might take more seriously, take a different attitude... I don't know what their policy is on home visits, if it's only for children under a year and people over seventy or, em, but I would have thought that if they knew that you weren't a time-waster because they knew you from the practice that they might look at it more favourably' (Ms. Leishman, MP 03-04).*

*Mutual knowing* and *mutual trust* between patients and doctors permeated these study data. The patient being known as trustworthy and legitimate, as having a moral identity, suffuses them. These facets of personal care were talked about as having a number of features and as serving specific functions. Their prominence in interviewees' accounts is such that the next chapter is dedicated to further discussion of them.

*Relational continuity* was viewed mainly as being given in the context of primary care, where continuity with one or a small number of GPs is on offer. Usually, patients did not feel such care could be provided within the hospital setting. Hospital care was perceived to be *'different'*. It was distinguished by the lack of continuity of medical staff during an acute episode or through a longer-term period of care. It was also distinguished by the patient usually not identifying with any particular health care professional and by not being treated as an individual, to whom the doctor has a broader responsibility for her own care or that of her family. Last, it was distinguished by the patient feeling she was often not actively involved by staff in the care process. In essence, this was said not to

constitute *relational continuity* because patient and doctor do not know one another, have no relationship and do not share a 'connection':

RA: *'Have you ever had any experiences in hospital where you feel you've had personal care...?'*

Mrs. Anderson: *'Well, not really, because in hospitals the doctors do their rounds and a lot of the time they come round with their wee students and they all stand there and discuss [her son]. I didn't like it because it would scare me and [her husband] and I would be standing there looking at one another while they were discussing **my child** [her emphasis, angry tone]'*.

RA: *'So, it sounds as though you feel that there is a bit of a difference between the care that you've had with Dr. Abraham and the care from the hospital in terms of it being personal care or not. Is that right?'*

Mrs. Anderson: *'Yes, you don't know these people anyway. There is no connection with these people. And it would be different if you were allocated the same doctor and everyday they came round and spoke to you personally, but that doesn't happen'* (Mrs. Anderson, MP 01-01).

In exceptional cases, however, personal care was viewed as occurring within the hospital setting. This was associated with seeing a small number of staff, the continuity that medical notes can bring and staff being caring and informative in their approach. In these cases, patients explained that continuity of medical personnel allowed for a degree of knowing between patient and staff and for patient involvement in the process of care. This lengthy data extract from Ms. Leishman shows the variety of ways in which personal care was given within a children's hospital setting:

RA: 'Do you feel that you get personal care in hospital...?'

Ms. Leishman: 'Em, yes, certainly it's based on my experience with children's hospitals, they may not be the same, but I think you get good personal care there, and you see the same consultant every day... He comes back twice a day to see how the patient is, em, including the registrars etc., who actually performed the operation with him, and nursing staff, you are assigned one nurse for the whole day ... Em, so, I think that is very good personal care and they know you, and you can read the notes all the time and they take account of, you know, the whole picture, em, whether the parents are in, whether the brothers and sisters have been in to visit, who is staying, as well as the medical side. There are quite detailed notes, if they have been happy, up and playing or not, and there was a play specialist who came in every day to see what the child wants to play with' (Ms. Leishman, MP 03-04).

Thus, what I have categorized as *relational continuity* was discussed by a few patients as possible within a short episode of care where the same practitioner, or small number of practitioners, attend the patient, staff take account of the whole person, communication between staff is good and parents are involved in the process, regardless of the care context.

### **The Similarities between Patients' and Doctors' Accounts of Relational Continuity**

Doctors also talked about personal care in terms of relationship with patients built over time in which *mutual knowing* and *mutual trust* are key features.

Paralleling patients' accounts, temporality as an essential ingredient of personal care was stated quite explicitly by several doctors:

Dr. Ibsen: *'... I suppose by definition, if I'm saying that how I, when we got your initial stuff [about the study], and I was thinking about personal care, and I was thinking very much in terms of continuity of care and length of relationship and things'* (Dr. Ibsen, MD 03-03).

Similarly, Dr. Strong exemplifies this recurrent theme in doctors' accounts when he responded to the initial interview question:

RA: *'... about the question of the personal doctor, I really wanted to ask you what that concept means to you?'*

Dr. Strong: *'Well, I think the essence to me of what General Practice is is that you have a relationship with a patient over time and, if you've been their GP for a number of years'* (Dr. Strong, PD 01-02).

In keeping with patients' accounts of personal care, this was articulated both as knowing the patient through a specific period in her life or, indeed, throughout the course of a lifetime:

RA: *'... what do you think about it [personal care] as a topic...?'*

Dr. Neill: *'I think personal care is very important... to me that is what, why we are doing General Practice, em, was to give personal, one-to-one care and to follow people through, in some cases, from birth to death almost'* (Dr. Neill, MD 04-02).

Similarly, doctors also discussed personal care in terms of being the *'family doctor'* providing care over time to the whole family:



RA: *'Em, so, maybe the first thing... is when you got the letter and you were approached about it [the study], were there any particular thoughts or feelings that you had about it as a research topic?'*

Dr. Quick: *'... Yes, we still see ourselves as family doctors, and so can derive a connection between different generations and siblings and so on...'* (Dr. Quick, MD 04-02).

Having a relationship with the whole family was also discussed by doctors in terms of providing care across generations of the same family:

Dr. Victor: *'I have patients now that I have known since they were babies, a lot of GPs have. I know granny, grandpa, mum and dad and children, so, I know three generations of family'* (Dr. Victor, PD 02-02).

Doctors also constructed personal care in terms of identifying with the patient. This could be either having exclusive responsibility for the care of the patient and her family or being responsible for co-ordinating care amongst a number of care providers. In both cases, it involved the doctor in having an ongoing commitment of care to that patient:

RA: *'... what do you understand by the concept of personal doctoring, or giving personal care..?'*

Dr. Roberts: *'I suppose, an important feature about it... it's an ongoing commitment really, it's not a one-off consultation with an individual patient, but it's kind of something over a prolonged period of time or, for which the doctor feels responsible for that patient, outwith a particular consultation. It also means being available, the patient knowing that the person they go to who will take that responsibility for it,...'*

*that's irrespective of whether they've been referred to some secondary place or whatever. It's a kind of ongoing commitment really'* (Dr. Roberts, PD 01-01).

Many of the above data extracts demonstrate that, in parallel with patients' accounts, knowing the patient was expressed as a central feature of *relational continuity*. Temporality was discussed as allowing the doctor to build knowledge of the patient. In a further typical example of such data, Dr. Gilmour commented:

Dr. Gilmour: *'... the uniqueness of General Practice is you know the patient very well, you often know them as friends, I like that...'* (Dr. Gilmour, MD 03-01).

As in patients' accounts, knowing was also expressed as being mutual in nature, with knowledge between patient and doctor being built over time:

Dr. Ibsen: *'... I was thinking about personal care... and, em, by definition, you really know each other and the relationship, you know ...'* (Dr. Ibsen, MD 03-03).

Last, again paralleling patients' accounts, doctors typically attributed trust between patient and doctor as a characteristic feature of personal care that developed as part of the ongoing relationship. It was discussed as being typified by the patient having trust in the doctor:

Dr. Abraham: *'I think personal care is two, I mean, has to have two aspects... there is the continuing personal care aspect, which actually is based on the trust of the patient, from having seen you in the past and having accepted some of the things, or most of the things, that you've dealt with, you've dealt with in*

*a professional or in a reasonable way'* (Dr. Abraham, MD 01-01).

Again, doctors talked in the same way as patients about trust, in that it was expressed as mutual. Doctors noted that, when they know the patient over time, they can usually invest greater trust in the information given by that patient about the presenting problem. The doctor knows whether she can, *'take [the patient] at face value'* (Dr. Franks, MD 02-03) or, as another doctor put it, to judge, *'whether the patient tends to over-estimate things or under-estimate things'* (Dr. Lorimer, MD 03-06).

The strong resonance between patients' and doctors' accounts of personal care, defined by the patient-doctor relationship over time, is evident in these data. However, one difference noted is that, as with doctors' talk of the use of self in the personal encounter, they also described personal care in this respect as requiring a use of self that one would not expect patients to comment on. It involved the doctor drawing on their personal resources beyond the strictly medical that could place strain on them both physically and emotionally:

Dr. Emmerson: *'... so you have to get the balance right between, em, being interested and wanting to help people, whilst not becoming so involved in their crises that it uses up something of you'* (Dr. Emmerson, MD 02-02).

I now wish to consider the data presented so far in this chapter in relation to the variables of practice size and deprivation score that were included in the study design, in order to examine any differences found.

## **The Meaning of Personal Care, Practice size and Deprivation Score**

These three ways in which interviewees talked about what constitutes personal care were not mutually exclusive in their accounts. Analysis within each interview, rather than thematically across the whole of the two data sets, showed most interviewees talked about all three ways simultaneously when describing what personal care means. Indeed, these three ways were distinct, but not discrete, categorizations and a relationship can be discerned between them, as I will discuss in the next section. This was the case, regardless of practice size and deprivation score of the practice area.

Whilst all patients from both small and large practices talked about what I have classified as *personal consultation style* and *whole practice care* in the same way, and with a similar level of emphasis, there were differences in the way that they spoke about *relational continuity*. Patients from small practices tended to regard personal care as the patient having a relationship with all or any of the small number of GPs in the practice. They did not emphasize as much as patients from single-handed or larger practices having an exclusive relationship with one particular doctor. This is evidenced by Mrs. Thomson from a small practice, who was noted earlier as saying that personal care was ‘... *not necessarily seeing a [her emphasis] doctor*’ (Mrs. Thomson, PP 01-01), but as building up a relationship with the doctors and other health care professionals in the practice. This compares to the typical example of Mr. George from a large practice, who was noted above as saying that ‘... *seeing your own doctor is [his emphasis] a personal service*’ (Mr. George, MP 02-04).

This difference may be due to the fact that in smaller practices patients have a greater chance of seeing all the doctors for the logistical reason that surgeries must be shared by the two or three practice partners. It seems reasonable to suggest this enables patients to get to know and be known by all of the doctors in the smaller setting and to build a trusting relationship with them in a way not so possible within the larger. However, within smaller practices, the emphasis on an exclusive relationship as an essential facet of personal care was notably greater when the patient or a member of her family suffered a complex, serious and worrying problem. In these situations of high emotional salience, patients in small practices usually expressed personal care as meaning a relationship over time with one specific doctor. As discussed earlier, Ms. Vickers is a typical example of someone attending a small practice but who, due to her daughter suffering multiple and life-threatening disabilities, described personal care as exclusive care from the one GP:

Ms. Vickers: *'We actually see the woman doctor, Dr. Strong, just because I've really built up a relationship with her...'*  
(Ms. Vickers, PP 01-03).

No differences were found in how patients constructed the meaning of personal care with respect to practice deprivation score.

Doctors from all the practices talked about the meaning of personal care in the same ways. Again, *personal consultation style* and *whole practice care* were talked about in similar ways by doctors from small and large practices. However, some variation was found in how doctors talked about it as *relational continuity*.

Doctors from large practices were relatively more likely to include the patient having a choice of doctor with whom she could build a relationship at different times in her life than those from small practices. For example, discussing his definition of what constitutes personal care, Dr. Gilmour from a six-handed practice stated:

*Dr. Gilmour: '... the patient can float around and find the style of doctor that suits them best... in other words, patients are entitled to see different doctors at different times about different things' (Dr. Gilmour, MD 03-01).*

No doctor from a small practice made patient choice a key aspect of what personal care means. Those doctors from the large practices, who did express such a view point, usually qualified it. Choice of doctor was excluded as an essential aspect of personal care for patients with complex and long-term problems and for those deemed 'abusive' or 'manipulative'. In these cases, continuity with one practitioner was considered necessary to effective management of the illness or control of the problematic patient's behaviour, as will be further elaborated in Chapter Six.

Again, no differences were found in how doctors constructed meaning in respect of practice area deprivation score. Nevertheless, it is clear from both patients' and doctors' data that the organizational context of care plays a role in the way meaning is constructed. These data suggest there is an inter-play between meaning construction and other factors, such as the nature of the health problem and the patient's perception and experience of that problem, as well as the doctor's view of the patient.

## **The Relationship between Categories of Personal Care**

As stated earlier, these categories of what constitutes personal care were not mutually exclusive in either patients' or doctors' accounts. As many of the above extracts of data will already have indicated, although what I have called *personal consultation style* was expressed as relating to the doctor's (or other health care practitioner's) manner, behaviour and attitudes within each individual consultation, patients and doctors mainly located it as occurring within the context of a relationship built over time. Most patients considered the doctor's consultation style in itself insufficient to be defined as personal care:

RA: *'So, you felt you got good personal care from the doctors at the surgery. Would you say that you get personal care from the doctors that come out that you don't know, I mean, in the out-of-hours service?'*

Mrs. Ewan: *'No, it's a totally different service altogether. ...It's maybe just a wee bit of advice... and just get some medicine in the morning and then off they go. It's just a totally different service than if you go in, in the surgery hours and see your own doctor'* (Mrs. Ewan, MP 02-01).

Indeed, consultation style was important and could go *'a long way towards'* getting personal care, but temporality was usually a required element of what constitutes such care, as evidenced by Mrs. Thomson:

RA: *'Do you think it's possible to get personal care within a one-off episode..., like you were talking about the out-of-hours service...?'*

Mrs. Thomson: *'I think it can go a long way towards it, I think it all depends on the doctor's attitude and the fact that they can sit down and spend time with the patient and find out enough about... their background, do they live alone, what their situation is and just an empathy to a large extent. It won't be the same as somebody who knows you, but I think just spending the time and explaining the treatment... I think that can go a long way to giving personal care... A lot is in personal relationships with the patient...'* (Mrs. Thomson, PP 01-01).

In a few accounts, care in which a particular consultation style was offered with an unknown practitioner in a single, one-off encounter was defined as personal, but these were atypical. In this example, Mr. O'Neill was describing a time when he attended a previously unknown doctor:

Mr. O'Neill: *'The nurse took the urine sample... and then the doctor, I went in and discussed my back problem with the doctor... the doctor gave an overall opinion...'*

RA: *'And would you say in that example that you got what you think of as personal care?'*

Mr. O'Neill: *'Yes, I think it depends on how you define personal care. I think each individual is going to have a different idea of what personal care is and it's quite interesting that it's perhaps not a statutory definition of personal care... but I think that, if I were to define personal care as my concerns being attended, then, yes... '*

RA: *'And the doctor's manner when you were there?'*

Mr. O'Neill: *'It was concerned, prepared to listen, provided some practical advice... dealing with what I felt was the seat of the problem... so, it was fine, yes'* (Mr. O'Neill, MP 04-03).



On the other hand, care from providers with whom a relationship had been built, but where no such consultation style was experienced, also did not constitute personal care in most accounts. Mrs. Thomson who, above, had talked about a certain consultation style with an unknown practitioner '*going a long way*' to make the care personal, also stated that temporality, in itself, was insufficient to constitute personal care:

Mrs. Thomson: *'It's not something that would necessarily follow ... if the doctor doesn't make someone, it has got to come from the doctor, too, of relating to the person they're dealing with... if you've got the kind of doctor who is very aloof and not really listening, he could see you twenty times and it wouldn't make any difference because they're not interactive...'*  
(Mrs. Thomson, PP 01-01).

In addition, there are numerous instances of patients who told negative stories of consulting a doctor over a lengthy period, which they stated did not constitute personal care due to the doctor's 'non-personal' manner and behaviour towards them. For instance, Mrs. Brown was describing a situation with previous doctors who had provided care to her family over a number of years. She went on:

Mrs. Brown: *'I just think he treats everybody like that... he's just and his [practice partner's] got a worse attitude than him. ... And, every so often I was getting constant urine infections, constant swelling of the stomach, violently sick, and she told me it was all in my head, and I never forgave her for that'.*

RA: *'Why did that affect you so much, do you think?'*

Mrs. Brown: '*... because you know there's something wrong with you and nobody's believing you, nobody's going to listen to a word you say...*' (Mrs. Brown, MP 04-03).

Thus, the main way patients constructed the meaning of personal care was in terms of the patient-doctor relationship built over time in which *mutual knowing* and *mutual trust* are key features. Having a *personal consultation style* was viewed by patients as an essential pre-requisite to the construction of personal care within the context of an encounter with a known or unknown provider. In a very few cases, temporality, though important, is not always required to constitute personal care.

In concert with patients, most doctors talked about personal care in terms of the patient-doctor relationship. All doctors in this study also described *personal consultation style* as an essential pre-requisite of personal care. Only a few doctors thought that consultation style alone could constitute personal care or that personal care was offered to all patients who consulted them. However, again, temporality, in itself, was not always deemed sufficient:

RA: '*What do you think the connection is between continuity and personal care?*'

Dr. Johnston: '*... I think it's perfectly possible to look after patients, em, provide whatever medical services are required to the best of one's ability, without having any kind of personal relationship with them at all*' (Dr. Johnston, MD 03-04).

Indeed, it was the human connection between patient and doctor that was usually described as essential to personal care in both sets of accounts. Such a

connection was said to develop over time. However, in a few exceptional cases, both patients and doctors noted that this connection could occur in a one-off encounter with an unknown patient when they shared a crisis or an especially important event in the patient's life. Mrs. Leishman, for instance, talked about the care she received from a previously unknown doctor at her own practice during a frightening episode of illness. Although she did not know him, she felt that his consultation manner, the attention he paid to her feelings of great anxiety, and the way he initiated follow-up treatment by phoning her several times made his care during that encounter personal.

Similarly, Dr. Wilson, when asked to say what personal care meant to him, replied:

Dr. Wilson: '*... sometimes something significant happens when a doctor witnesses an episode in a patient's life and there's no substitute for that...*' (Dr. Wilson, PD 03-01).

In both patients' and doctors' accounts *whole practice care* was articulated as being supportive of personal care given by the doctor in a single encounter or a longer-term relationship. Patients' accounts of good reception staff manner and practice organization of care that was perceived to be personal did not preclude 'negative' examples of non-personal care from individual doctors in that practice. Likewise, poor reception staff manner and organization of care that was not perceived to be personal co-existed in accounts of receiving personal care from practitioners. *Whole practice care*, then, sits alongside the other two categories supporting, but not essential to, patients' and doctors' understanding of what constitutes personal care.

## Summary and Discussion

In this chapter, I have tackled the first research aim of how patients and doctors construct the meaning of personal care in General Practice. These data, therefore, arose mainly from pre-set research questions. I have presented data showing that the term, personal care, had little currency with many patients, and also with some doctors. Overcoming the problem of terminology and engaging interviewees in discussion of the concept's meaning was aided by exploring what does *not* constitute personal care. Interviewees were asked to say what they thought personal care was *not* and to give an example of a time when they had *not* received/given such care. I also noted that interviewees often raised such examples themselves without prompting. This proved to be an invaluable technique for delineating the meaning this concept holds.

The work of Fox (1993) is helpful in understanding why this might be so. He refers to postmodernist thinking, particularly Derrida's analysis of *différance*, which concerns the *undecidability* of language and its continual *deferral* of meaning. By *deferral* he means the '*slippage of language which occurs as soon as one tries to pin a concept down*' (Fox, 1993: 7). *Différance* inevitably arises when using a language or, for that matter, any other symbolic mode of representation in which signifiers can refer not to an underlying reality but to other layers of signifiers. According to such thinking, exploring the meaning of a concept such as the personal does not lead us to reality but to some approximation that itself is not recoverable. Fox explains that the theory of *différance* is derived from semiotics, which sees language constituting meaning not in terms of what

something *is*, that is the 'essence' of a thing, but in terms of its difference from other things. He concludes that this requires us to abandon any essentialism in our search for the real and instead to see the '*movements of différence that constitute the world*' (Fox, 1993: 8). It is in the difference between what personal care is, and what it is not, that this concept was enquired about, discussed and constituted.

Notwithstanding the problems of terminology, the ideas underlying the term, personal care, were used spontaneously and with significant similarity within and between the two sets of interviewees. The main way interviewees talked about personal care was as that given in the context of a relationship with one or a small number of doctors built over time, characterized by *mutual knowing* and *mutual trust* and in which the doctor shows a particular consultation style. *Mutual knowing* and *mutual trust* involved the experience of an interpersonal connection between patient and doctor. These are significant themes which run through the data presented in all three findings chapters.

The patient's individual biography, the patient 'as person', is at the centre of interviewees' construction of personal care. The data show they emphasized the patient's individuality and need for a response and treatment that were not standardized, but tailored to meet her specific and idiosyncratic needs. The patient as sentient being, whose subjectivity and point of view are at the heart of the medical encounter, was clearly invoked. This invocation included an emphasis on the patient's '*interiocity*' (May *et al.*, 1996; Armstrong, 1982 and 1984), the patient's inner world of personality, thoughts and feelings, as well as

her wider family and social context. These spheres of knowledge were regarded as legitimate and necessary for the doctor to provide good, personal medical care, and these will be more fully explored in the next two chapters. In essence, interviewees were drawing on and engaging with the discourse of bio-psychosocial medicine in their accounts of personal care.

The use of the discourse of bio-psychosocial medicine in these data reflects the rhetoric and stated values of General Practice literature, as well as those of allied 'helping professions' such as social work, nursing and psychiatry, as discussed in the literature review chapter. I also showed there that modernist perspectives mainly theorize about such an approach as evidence of the increasing 'medicalization' of society, the means by which the regulation and control of society by medicine is established and perpetrated.

Further, I discussed how Armstrong (1979; 1984; 1987) draws on the work of Foucault to argue that this emphasis on the individual as 'person' in both the helping professions and in social science, whilst claiming to advance progressive ideals of the 'Humanist Enlightenment', is actually the effect and technique of new codes of knowledge which regulate society. Armstrong's thesis is that the discourse of bio-psychosocial medicine (what he also refers to as 'biographical medicine'), developed in the post-war era of many Western cultures, has become the dominant discourse of General Practice medicine in the UK and, although disguised as a humanitarian endeavour, is merely another strategy of *disciplinary* power. The centrality of the discourse of bio-psychosocial medicine in these study data is, arguably, a reflection of General

Practice medicine as a main site of *disciplinary power*. They also suggest that patients' and doctors' adoption of such a discourse is empirical evidence of the unwitting part they play in the exercise of that power.

The bio-psychosocial discourse of medicine adopted by patients and doctors in this study permeates General Practice literature in a number of guises. These data resonate with the way the personal has been implicitly conceptualized, operationalized and discussed in much previous empirical and theoretical work, as outlined in the literature review. For instance, the personal has been conceptualized as care within a single encounter in which the doctor shows a specific consultation style (Henbest and Stewart, 1990; Grol *et al.*, 1990; Howie *et al.*, 1992; Stewart, 1995). It has also been conceptualized as pertaining to the patient-doctor relationship, both as encompassing a therapeutic component (Balint, 1964) and as continuity of carer (Ettlinger and Freeman, 1981; Hjortdahl and Learum, 1992; Freeman and Richards, 1994; Baker and Streatfield, 1995). In terms of relationship, it has also been conceptualized as the patient's and doctor's identification with, and knowledge of, one another, and the doctor's sense of responsibility toward the patient (Hjortdahl and Borchgrevink, 1991; Howie *et al.*, 1999).

The way in which interviewees talked about personal care also generally concurs with the findings of Preston *et al.*'s. (2001) study of the meaning and importance of personal care in General Practice. They identified the same three categories of meaning used by both patients and health care professionals to construct this concept: as care within a single encounter in which a particular consultation style is shown; as care provided by the whole practice; and as care



provided by one carer over a period of time. However, the findings of this thesis depart from Preston *et al's* study in one major way. My analysis shows that these categorizations are not mutually exclusive. Analysis within each interview shows that they were all talked about simultaneously by most interviewees, and that a relationship may be imputed between them. For care to be personal, *personal consultation style* was an essential pre-requisite of, but usually insufficient in itself to constitute, such care. For most interviewees, it had to be provided in the context of an ongoing relationship with one or a small number of carers (*relational continuity*), in which the *mutual knowing* and *mutual trust* pertained. *Whole practice care* facilitated, but did not preclude, personal care from the individual practitioner.

The data presented here also show personal care was regarded mainly as occurring in a primary care context. A few interviewees thought it could be given by hospitals in certain circumstances, but this was exceptional. It was usually deemed not to be given, and was not even expected, from the out-of hours service. Practice context (size) was also found to impact on how personal care was defined and obtained. Patients from small practices usually claimed to know all of the doctors in the practice and regarded any or all of them as providing personal care. Patients from larger practices did not feel they knew all the doctors and usually mentioned one, perhaps two, whom they identified as their personal doctor. Logistical reasons related to the organization of surgeries have been suggested as an explanation for this difference. However, exclusivity of care from one practitioner was included as an aspect of personal



care by patients from small practices when dealing with complex, serious and chronic health problems.

Likewise, doctors from large practices talked about patient choice of health care professional as an aspect of personal care, whereas this was relatively less prominent in accounts of doctors from small practices. However, data show that doctors would qualify this: choice of practitioner was omitted as an aspect of personal care for those patients with complex, serious and chronic problems and those patients deemed 'problematic' and 'abusive'. Thus, patients' and doctors' data indicate that other factors play a role in the way meaning is constructed. These include the organizational context of care, the nature of the health problem and the patient's perception and experience of it, as well as the doctor's view of the patient. Other factors that have not been examined in this thesis may also influence and inter-play with how the meaning of personal care is constructed, and more research will be required to identify and explore these. No variation was found in patients' or doctors' data about how personal care was constructed by deprivation score of the practice area.

In summary, the data presented in this chapter demonstrate that patients' and doctors' construction of personal care in General Practice is multi-faceted. It encompasses a number of different co-existing, complimentary and related ideas. It draws upon and is embedded within the wider discourse of bio-psychosocial medicine. As the Research & Development Scoping Exercise (NCCSDO, 2001 a) suggests in relation to continuity of care, such concepts are not static and uni-dimensional, but are constructed and attributed with

importance in the context of people's wider circumstances. The contextual nature of the importance and value personal care holds for patients and doctors is dealt with fully in Chapter Six.

In light of this chapter's findings, it is perhaps not surprising that definition and operationalization of concepts that implicitly embrace the personal for measurement purposes has proved to be difficult. Reducing such a concept to component parts and de-contextualising it, as required by some of the outcome measure research I have reviewed, is problematic. To date, no known work has attempted to encapsulate the different ways that personal care was constructed in this study into a working definition, by combining these aspects of *consultation style*, care from the *whole practice* and the attributes of the *patient-doctor relationship*. This may help to explain why previous research has produced the contradictory and inconclusive results outlined in the literature review that have so 'disappointed' (Howie, 2002) those committed to a bio-psychosocial approach to medicine.

I now wish to explore further the way that *mutual knowing* and *mutual trust*, as key characteristic features of personal care, were discussed by interviewees in this study.

# CHAPTER FIVE

## Mutual Knowing and Mutual Trust

*'Information about the individual helps to define the situation, enabling others to know in advance what he will expect of them and what they may expect of him. Informed in these ways, the others will know how best to act in order to call forth a desired response from him... If they know, or know of, the individual by virtue of experience prior to the interaction, they can rely on assumptions as to the persistence and generality of psychological traits as a means of predicting his present and future behaviour'* (Goffman, 1972: 13).

### Introduction

I explained in the last chapter that most patients and doctors talked simultaneously in interviews about personal care in three distinctive, but overlapping ways, and a relationship could be imputed between them. The main way personal care was constructed was as care given within a relationship built over time, characterized by *mutual knowing* and *mutual trust*, in which the doctor shows a particular consultation style. In Chapter Four, the data I presented illustrate how interviewees talked about what personal care means to them whilst in this chapter, I want to focus more closely on many of these data in order to examine what they tell us about the nature of knowing and trust.

Unlike those themes considered in the last chapter and those to be considered in the next, the themes of *mutual knowing* and *mutual trust* did not arise in response to pre-set research questions, but were identified during data analysis. This chapter describes, first, two aspects of *mutual knowing*; what I have termed 'factual knowledge' and 'interpersonal knowledge'. For both patients and doctors, *mutual knowing* served a range of functions, and was closely linked to the establishment of *mutual trust*. The chapter then goes on to describe how patients and doctors placed boundaries around knowing and being known. For patients, these boundaries were related to how the patient and doctor should know one another, and they were contingent upon the nature of the health problem. Patients also circumscribed how they should know one another in social terms, and this was the main way that doctors circumscribed patients' knowledge about them. Finally, the chapter demonstrates that *mutual knowing* was sometimes treated in these accounts as problematic by both patients and doctors.

Like accounts of the meaning of personal care, patients' and doctors' talk of *mutual knowing* and *mutual trust* were strikingly similar, with only a few differences in emphases noted. Again, I discuss the similarities and differences at the end of each main section. Minor differences were found in accounts of these two themes between practices by both practice size and deprivation score.

The study's findings that personal care was talked about both as beneficial and as potentially problematic are considered against the background of previous quantitative research that has dominated the study of this topic.

## **Factual knowledge: The Doctor Knows the Patient**

In the analysis presented in this chapter, I distinguish between *'factual'* and *'interpersonal'* knowledge. These labels are not ideal, in that factual knowledge does not refer exclusively to the doctor holding 'facts', and may include an element of the doctors' assessment or judgement about the patient. However, the label helps to distinguish this kind of knowledge from the other main one that is more relationship-oriented and experiential in nature.

Factual knowledge includes doctors having information about the patient's medical history, such as recent illnesses, prescribed medications, periods of hospitalization and response to previous treatments. When talking about what personal care means to them, interviewees said it included being known by the doctor. I, therefore, asked patients what information the doctor had about them. Ms. Jackson exemplifies the typical response:

Ms. Jackson: *'Just all the previous appointments, treatments given, operations, just all the medical history'* (Ms. Jackson, MP 03-02).

Medical information often included knowing about both the patient's physical health and emotional wellbeing, and could include the doctor's awareness of the patient's individual personality, for example:

Mrs. Thompson: *'... I think they need to have built up some kind of relationship with you and have assessed what kind of*

*person you are. Are you somebody who instantly panics every time your child has a cough...?' (Mrs. Thompson, PP 01-01).*

Indeed, knowing the patient's personality and how she would usually respond to events, was emphasized by Ms Grange:

*Ms. Grange: '... it's knowing more personal traits, knowing how an individual person would react to situations' (Ms. Grange, MP 02-03).*

In addition, patients typically described being known as the doctor having information about their wider family circumstances. This includes the medical history and current health status of family members:

*RA: 'How would you describe having your own doctor, what does that actually mean to you?'*

*Mrs. Quinton: 'A doctor that knows really, all there is to know ... he knows about medical problems, family health, you know. ... he'd have a fairly good idea of your family in general, you know, that to me is the sort of, you know on a one-to-one... that's what I regard as "my family doctor", somebody that knows a bit of me, and of my family' (Mrs. Quinton, PP 02-02).*

The doctor knowing about the patient's family health status was regarded as a legitimate, and sometimes essential, part of the doctor's knowledge. It was often expressed as allowing the doctor to understand the patient's complaint in light of other family members' health.

Patients also talked about doctors understanding their domestic and social circumstances. This is exemplified by Ms. Vickers, who had recently experienced a vitriolic divorce and whose daughter suffered multiple, chronic and life-threatening health problems:

Ms. Vickers: '*... when I first split up from my husband... I had a lot of trouble with my son and it got to the stage, talking about whether we would have to go to family psychiatry unit and she was very, very sympathetic on that front because she knew the whole family picture... it did help, she was very sympathetic, because she knew that a lot of [her son's] problems were being caused by [her daughter's] situation*' (Ms. Vickers, PP 01-03).

As indicated here, more general information about the family included: any significant generational or more recent family history, current family relationships and family-related problems. It also sometimes included the family's economic circumstances, such as employment status or experiencing financial hardship. Indeed, patients' adoption of a bio-psychosocial approach to health and illness was evident throughout these data on knowing and being known.

Patients' tendency to adopt a bio-psychosocial perspective made even more explicit than the above data demonstrate. It was repeatedly expressed as the doctor knowing, for example, the '*whole person*' and taking a '*holistic*' approach. For instance, I invited Mrs. Mooney to expand on her reference to the word *holistic*:

RA: *'Do you think that the doctor having a wider approach, you mentioned the word 'holistic', do you think that that is important or not?'*

Mrs. Mooney: *'... I would imagine that makes the GP's job a lot easier if he has the whole picture and he is also able to make an accurate, you have a more accurate sort of history and therefore you can make a more accurate stab at things...'* (Mrs. Mooney, 04-01).

Similarly, when asked why receiving care from a doctor who knows the patient is important, Mrs. Thomson replied:

Mrs. Thomson: *'Because I think a lot of your physical health has, a big factor of your physical health is your personality, your lifestyle, your emotional stability and your level of happiness, etc., are all affected. They all affect your actual physical health, because, you know, you're not just a machine you know...'* (Mrs. Thomson, PP 02-04).

The important theme of the benefits brought by personal care, alluded to in some of the above extracts, is discussed in more detail in the next chapter.

### **Factual knowledge : The Similarities and Differences between Patients' and Doctors' Accounts**

Like patients, doctors also talked about knowing the patient in a factual way in relation to the individual's medical history, response to previous treatments, general well-being, personality and tendency to react to situations:

RA: *'Right, so in those two situations... you mentioned the idea of "knowing" as being linked to a relationship in those*



*situations... could we just explore a wee bit about what you mean by "knowing" them...?'*

Dr. Johnston: *'... knowing the kind of things that make them tick, em, interests, what kind of work they do, what kind of problems they have, or have had in the past, psychiatric problems, medical problems, em, whether they have drink problems for example, em, I mean just, everything about them, what they actually, how they function' (Dr. Johnston, MD 03-04).*

Paralleling patients' accounts, doctors also regularly included having information about the patient's family as appropriate knowledge, sometimes by being the family doctor. This was expressed in terms of family medical history as exemplified by Dr. Abraham:

Dr. Abraham: *'... but, it is easier to help patients if you know more about them'.*

RA: *'What would you say is the kind of thing that you feel it's important to know about?'*

Dr. Abraham: *'If there are illnesses in the family, if you can, you don't remember everything about families, but if you are involved with extended families and you know what's going on in families, illness-wise, or other things, you can talk to people about those concerns as well. They appreciate that, and sometimes a lot of it, it can bring it to perspective, you know' (Dr. Abraham, MD 01-01).*

As Dr. Abraham implied, it was also expressed in terms of wider family circumstances, such as family history, current family relationships and family-related problems, as well as the family's broader social and economic position.

Dr. Benton, for instance, made a clear connection between having this contextual information about the patient and the doctor's ability to deliver personal care:

RA: *'... you mentioned knowing quite a lot [about patients]. ... you mentioned, for instance, quite a lot about knowing about family members. Is there anything else like that, that's important?'*

Dr. Benton: *'I like having some idea... [about] their level of intelligence, their level of understanding about things that you gauge, sort of... em, I guess, work environment, people as well is important, sort of general social situation is very important. I guess, you can tell by their dress if they're in some of the worst places, em. What else would you know from just general? I think just knowing about what's, we have a sort of light industry area near us, and certainly things have shut there, which have had a knock-on effect on our local population, certainly on those who work in sort of menial jobs, or in those places nearest to them and then something happens there, you know that that's going to have a knock-on effect on the community. We obviously have a relatively bad drug problem, em, and knowing how that sort of is, in relation to people that you see'* (Dr. Benton, MD 01-02).

Thus, like patients, doctors talked about knowing the patient in a factual sense across the three spheres of knowledge: the patient as an individual; the patient's family medical circumstances; and the wider context of the family's domestic, social and economic situation. In concert with patients' accounts, doctors' emphasis on the need for such wider knowledge reflects their general adoption of a bio-psychosocial approach to medicine. Knowing the patient in these ways was credited with allowing a patient's individual symptoms to be understood in

context. Holding such information was justified as facilitating the provision of good quality medical care. Again, the important theme of the benefits of personal care will be discussed in more detail in Chapter Six.

## **Factual knowledge: The Patient Knows the Doctor**

As well as being known by doctors, patients talked about knowing the doctor as an aspect of personal care and referred to what I have called factual knowledge.

Factual knowledge encompassed knowing about the doctor's clinical skills, including her general medical competence and any particular medical interests and areas of expertise. For instance, Mrs. Richardson explained she knows from experience that her doctor is medically competent and he will be able to sort out clinical problems that other, unknown doctors may not:

RA: *'Is there any other reason why it [seeing the known doctor] is important to you?'*

Mrs. Richardson: *'... with a different doctor, they come out with the wrong treatment because they've gone down the wrong track. If I'd went to Dr. Victor, that wouldn't have happened...'* (Mrs. Richardson, PP 02-03).

Further, Mrs. Peters provided a typical example indicative of patients' knowledge, this time showing awareness of the doctor's specialist area of interest. She had already explained that, whenever possible, the family attends Dr. Ure because they know and like his consulting style and feel a 'connection' with him. She added:

Mrs. Peters: '*... I think if it was anything to do with epilepsy, he [her husband] would try to see Dr. Ure, because, again, he knows Dr. Ure's studied it and knows a bit more about it...*'  
(Mrs. Peters, PP 02-01).

Some patients stated that, whenever possible, they choose to see the doctor they know to have a specialist interest or to be more suited to dealing with a particular type of problem. For example, one doctor from a small practice was said to be good at sports injuries, whilst another (the female partner) had most experience in dealing with gynaecological problems. The 'sports injury' doctor was also described as being known as someone who could best deal with the 'softer' issues of family relationship problems.

Knowing the doctor also incorporated knowing her consultation style. Many of the attributes of this style were discussed in Chapter Four as constituting one category of what personal care means to patients. The further relevance of these data is that patients emphasized they know from experience, and so can predict, the response of the doctor to them when consulting.

Knowing the doctor, in this respect, was articulated as patients being aware of the doctor's general manner and body language, and the way they would be treated both in human terms and also clinically, once at the consultation. They included features such as knowing; whether the doctor would '*listen*' to the patient, '*maintain eye contact*', '*take time*' with the patient, be '*judgmental*', '*patronising*' or '*dismissive*' of the patient, and exhibit other 'human' qualities, like having a '*respectful*' manner or showing compassion towards the patient.

Mr. and Mrs. Uphall, for instance, agreed that amongst their doctor's known attributes was, not only his medical competence in certain areas, but also his favourable consultation style:

Mr. and Mrs. Uphall: *'... I'm quite impressed with Dr. Roberts because he will look at you and he doesn't start writing until you finish your conversation... And this wee bit extra, either you say or they drag it out of you, or they ask a wee bit more... five different things could cause the same symptom... doctors fall down on, but Dr. Roberts doesn't. He waits until you're finished your conversation and then he writes you out a prescription... But, overall, Dr. Richards is a good doctor, because he's got that "extra"'* (Mr. and Mrs. Uphall, PP 01-02).

Similarly, Ms. Hamilton talked about what she knows about the doctor's consultation style in these terms and, here, included having knowledge of his 'nature':

RA: *'So, you were saying that he was 'nice'. What is it about him that's nice apart from the fact that he explains things?'*

Ms. Hamilton: *'... he has just got that nature, he is easy to talk to... Some doctors you sit down and they are so stern. He is so relaxed. He is just like a normal person. It's strange, he has just got a nice manner about him... Well, when he is speaking to you, he looks at you. He is not playing with his computer... he talks face-to-face with you. Whereas, some of them are looking and doing something else, he speaks face-to-face. And he says, "Do you understand that"? And he is the type of person that if you said, "I don't understand that", he will explain it'* (Ms. Hamilton, MP 02-04).

Finally, patients talked about knowing the doctor 'as a person'. Patients made reference to the doctor's personal, individual characteristics and, sometimes, to those of her family. References were made to the doctor's gender, age and marital status, whether she had children or had experienced a similar personal or medical problem.

For instance, Mrs. Quinton, who had already drawn on Dr. Victor's personal circumstances to explain her choice of doctor, also cited the doctor's personal biography as playing a role in facilitating her being 'understood' and in getting the best medical treatment:

*Mrs. Quinton: '... Dr. Victor, she's also a mum and her kids are about the same age as mine and she's been very sympathetic on a personal level, too... One of her good points... because she's a mother as well... when it's related to the children or that, she'll come over that way, maybe an older doctor... a male doctor might not have the same understanding of things...'*  
(Mrs. Quinton, PP 02-02).

Similarly, patients remarked on how knowing their doctors' personal circumstances, or of them having a similar problem or experience, helped them to give good treatment. Patients seemed to appreciate the sharing of such information and perceived it to facilitate resolution of the problem. Mrs. Mooney reported being helped by this when faced with a medical dilemma:

*RA: '... you were sort of talking about you knowing the doctor'.*

*Mrs. Mooney: 'Yes... he is always very pleasant, professional. His dad was a GP and by all accounts a very good GP, as well.'*

*... I know with the children's vaccinations... I've always said, because he has children himself, "and what would you do?" It's quite tricky as a parent, you read endless literatures, and some are pros and some are against it... and it's very difficult to make your mind up... I've always asked what he did with his children and he had all of them done, so did I' (Mrs. Mooney, MP 04-01).*

As evidenced above, patients usually explained knowing the doctor 'as a person' in terms of it facilitating provision of care in some way. In other words, having this sort of knowledge was often perceived to be relevant and legitimized by reference to medical need or standards of care. However, it was also articulated as being of importance for its own sake. In other words, knowing and being known in these ways were considered to have a function in the patient's experience of the care provided, not only in achieving the desired medical outcome. The emphasis in these data on the *experience* of care and not just on the *medical outcomes* resonates with those presented in Chapter Four and is an important theme that will be further explored in the Chapter Six.

### **Factual Knowledge: The Similarities and Differences between Patients' and Doctors' Accounts**

Doctors talked about what patients know about them in relation to factual knowledge in very similar ways to patients. Dr. Abraham exemplifies when he talked about the patient knowing something of the doctor's general medical competence:

*Dr. Abraham: '... there is a continuing personal care aspect, which is actually based on the trust of the patient from having*

*seen you in the past... that most of the things you've dealt with in a professional... way... if you are medically confident, they're going to see you because your medicine's good...*' (Dr. Abraham, MD 01-01).

Doctors regularly noted that the patient knows the doctor remembers her, is familiar with her medical history and, sometimes, her wider family and social context, and is generally medically competent and trustworthy. However, few doctors commented that patients were aware of the doctor's special medical interests or areas of expertise, as patients had noted.

The patient knowing about the doctor's consultation style was a significant feature of doctors' accounts. This includes how caring and attentive the doctor is in the consultation and how likely she would be to respond to the patient's presenting problem, based on previous experience. Dr. Benton, for instance, had already stated that personal care to her essentially encompassed knowing the patient and being known. Here, she expanded upon this in relation to her own consultation style, when asked:

RA: *'And when you talk about personal care, what does that sort of suggest to you, what kind of thing does it make you think about?'*

Dr. Benton: *'Really, the major thing it means to me is that I have some idea of where that person's coming from and they're coming to see me, having some picture of who I am in advance and I hope I give the impression that I'm very happy to sit there and be told anything, and, sort of, will be an open canvas for whatever needs to happen'* (Dr. Benton, MD 01-02).



Similarly, Dr. Ibsen talked about personal care, not only as meaning the doctor knowing the patient, but also as the patient knowing in advance how the doctor would react when consulted:

RA: *'And I just wondered what you thought about that idea of you "knowing the patient and the patient knowing you". It's kind of implicit in what you've been saying. I wondered if you thought that was important in giving personal care?'*

Dr. Ibsen: *'Yes, yes, that's right, I suppose by definition... you really know each other and so, that's fairly, yes, that's a central part of the relationship, you know, that you know each other's expectations and, I think, you assume that you're working along similar lines most of the time...'* (Dr. Ibsen, MD 03-03).

In addition, also paralleling patients' accounts, doctors noted that patients sometimes had an interest in, and knowledge of, them as people and their personal circumstances beyond their medical work at the practice. I noted during the interview with Dr. Kerry, for instance, that she had pictures of her family on her consulting room wall. When I asked about these, she discussed how she deliberately uses reference to her own family in consultations and, thus, patients know something of her own family situation:

Dr. Kerry: *'I probably too often mention my family... But, sometimes, it's quite nice if you can say to elderly patients, "Oh, yes, my mother-in-law is in that same situation. I know how difficult it must be" or, you know, they get to know about my children, too'* (Dr. Kerry, MD 03-05).

Indeed, some doctors mentioned that their relationship with some patients extended to them being regarded as *'friends'*, in the sense that both parties know something of the other's personal circumstances:

Dr. Johnson: *'... because we work and live in a fairly settled urban area, quite a lot of patients we know as friends. So, I mean, you know people on a sort of social level, as well. They'll know my wife, they'll know my children, they'll know where I live, and, so, they will know me as a friend, as well as a doctor...'* (Dr. Johnson, MD 03-04).

Thus, once again, there is evidence of considerable consonance between patients' and doctors' accounts in relation to what knowledge each party has of the other. However, doctors also regularly talked about how they obtain this factual knowledge of patients, whereas patients did not. They talked about gaining factual knowledge of a patient in a number of ways that I have categorized, as follows: First, doctors described explicit *information seeking*, particularly during the first consultation, by means of a standardized information form or mental check-list. This questioning was talked about as an essential part of the craft of being a 'good' GP. Although it was discussed as an important aspect of the initial contact phase, it was also often described as continuing throughout the life of the relationship. This was justified by the need to take account of patients' changing circumstances. For instance:

RA: *'Mmm, hmm, and you mentioned the words there, 'meaningful contact'. Could you tell me a wee bit more about what you understand by that? I mean, I take it you're relating that to your notion of personal care, am I right in saying that?'*

Dr. O'Reilly: 'Yes. Well, I think, I think certainly from my point of view, eh, the two elements are, am I building a knowledge of the patient and their life and their health? And that starts with factually recording elements about patients which I was taught by my trainer, em, and is a page of questions,...simple answers take about seven minutes to ask, but it goes down, I'll show you it later, but it's about seven times as much as most GPs appear to ask, or certainly appear to record, which I find very disappointing, em, when I look at records that come from other practices, and you see, "plumber, tonsillitis, penicillin..."' (Dr. O'Reilly, MD 04-02).

Second, doctors discussed obtaining factual knowledge of the patient in a way I have categorized as *information offering*. This is where information is said to be offered by the patient at the outset of contact and during the course of the relationship, which is not initiated by the doctor. It can arise out of 'social' conversation or during the main part of the consultation when patients reveal information they feel is relevant to the presenting problem. Doctors talked about encouraging this opening up by, as Dr. Benton above put it, appearing to be '*an open canvass*' (Dr. Benton, MD 01-02), ready to hear anything the patient wishes to discuss.

Third, factual knowledge was talked about as obtaining knowledge either through direct knowledge of a patient's relation or another member of staff knowing the patient or her family. Indeed, the doctor having knowledge of a family member was expressed as saying something about the individual:

RA: '*And you said earlier, as well, about being attracted to general practice is because you feel you get to know the person?*'

Dr. Clarke: 'Mmmm, hmmm'.

RA: 'Could you tell me something about what it is that you feel you want to know about them when they come in, what's the ... [interrupted sentence]?'

Dr. Clarke: 'Well, it's an idea to have an idea of background, because not everybody, particularly in an area like [name of area], there's a lot of deprivation, a lot of social problems. A lot of families which will come in, and speaking to more experienced doctors, it's very useful to know the family, because they may have seen a family member...' (Dr. Clarke, MD 01-03).

I have called this way of knowing *third party, locally produced information* as it was expressed as information gathered by means of the pooling or sharing of 'local knowledge' within the community by those who work there, as illustrated by Dr. Clarke. It was also sometimes talked about as being derived from staff members who lived in the area. To exemplify this, reception staff living in the community were said to play a role in gathering information about patients in this way:

Dr. Franks: '... I think that the reception staff usually know exactly what's going on in the practice, especially at my old practice, they knew absolutely everything. You know, if you wanted to know, they all lived in the town, and they knew everything about everybody, and I think they were such a vital source of information, you know...' (Dr. Franks, MD 02-03).

Practice staff were said to share third party, locally produced knowledge both informally and more formally at staff meetings. Such an exchange of information between staff members was considered to be good practice.

The fourth and last way in which doctors described obtaining this factual knowledge was through *official information*, such as medical records. This information was said to be helpful if the doctor does not know the patient. However, written information was generally deemed to have significant limitations and was considered a poor substitute to having direct knowledge of the patient. For example, Dr. Kerry, comparing attending her own patient or one of her practice partner's, where notes are available, to an unknown patient through the local out-of-hours service, where notes are not available, remarked:

Dr. Lorimer: *'... if someone's [a practice partner's] on holiday, it seems to be Sod's Law that some of their chronic problems flare up and, I mean, I find that a nightmare ... it's much easier to deal with your own, sort of chronic patients than someone else's'*

RA: *'To what extent do the notes that you get help you in that situation, would you say?'*

Dr. Lorimer: *'Em, oh, definitely, it's much easier to see one of our partner's chronic patients when they're not there because we've got the notes than to see someone from [name of local out-of-hours service] where you have no access to notes. So, it definitely helps, but people don't, I suppose, they don't record everything. You couldn't possibly... the notes, I suppose, aren't complete, so, it helps a bit, but it's still not as easy'* (Dr. Lorimer, MD 03-06).

Doctors stated that, in general, having some direct knowledge of the patient was by far the most helpful to them in providing what they considered to be good personal care. When needed, their own notes were regarded as useful in

'triggering' other information in the doctor's memory which had not been recorded.

## **Interpersonal knowledge: The Patient and Doctor Know One Another**

The patient and doctor knowing one another was expressed in a further, quite distinctive way that is more relationship-oriented and connected to the existential or interpersonal experience of the contact. Being more nebulous in nature, this aspect of knowing is difficult to characterize and label, and I have termed it 'interpersonal knowledge'. Patients also had some difficulty articulating this particular way of knowing, indicating its somewhat ephemeral quality and the lack of a language to express its meaning in a clear and precise way. For instance, Mrs. Quinton was attempting to explain the difference between her experience of her own doctor, whom she has known over many years, and an unknown doctor:

*Mrs. Quinton: 'I've went to see another doctor within the practice and sort of said, "Well, no, I won't go again", because of a different attitude, but someone that's went for the same length of time as I've been going to Dr. Victor probably would have the same rapport as I have... '.*

She went on later in the interview to say:

*Mrs. Quinton: 'It's not just going and saying to the doctor "It's this or that's maybe wrong, what can I do for this?" or, "What would you give for to sort that?", which you would maybe do with another doctor. You go in and you say to her,*

*"It's this or that", and she'll ask you this, and just, it's different, more personal and more 'this' [puts hands in the air and gesticulates with fingers to indicate lack of words].*

RA: *'More 'this' [copies gesticulation]. I know what you mean when you do that'.*

Mrs. Quinton: *'It is more 'this', but how do you put 'that' [gesticulates again] into words? It's more all round, sort of, a bit of everything... you're getting a bit of the personal as well, a bit of 'that'' (Mrs. Quinton, PP 02-04).*

It became clear, as I pursued the theme of knowing in subsequent interviews, that many interviewees were not talking exclusively about *what* the doctor knew. Being known also incorporates the *way* in which the patient and doctor know one another. In this sense, patients articulated this way of knowing as encompassing '*familiarity*' and '*recognition*', mutual liking, feeling '*comfortable*' or having a '*rapport*' or '*connection*' with the doctor and, sometimes, as sharing an emotional bond. Indeed, knowing was often expressed in emotional terms.

A further example that highlights the conceptual difference between the two categories of factual and interpersonal knowledge, and the relative importance placed on each, is contained in the next extract. In this case, Mrs. O'Neill had already lamented not receiving what she perceives to be personal care. She attributed this to the lack of time allowed by the system for the patient and doctor to develop a '*relationship*'. She had likened personal care to seeing the known doctor, who should inhabit the role of a '*20<sup>th</sup> Century Priest*'. However, despite a lack of time causing difficulties for her in getting such care, she had

explained that she always endeavours to see her own doctor, even if that means a protracted wait. When asked why, she replied:

Mrs. O'Neill: *'Because I want to enter into that relationship and I want her to know how I am, and I feel that she wants to know how I am, because she's a nice person, so, em, it's both ways, I guess'.*

However, when I then asked her *what* the doctor knew about her, meaning in a factual sense, this way of knowing was seen to be relatively unimportant:

RA: *'And what kind of information do you think that your doctor, Dr. Paul, has about you or needs to have about you...?'*

Mrs. O'Neill: *'Well, probably what she has when she first met me, I think that's probably enough...'* (Mrs. O'Neill, MP 04-03).

To emphasize this point, when asked what being known by the doctor means to her, Mrs. O'Neill stated that it was only for the doctor *'to know how she is,'* to take an interest in her and enter *'into that relationship'* with her. For Mrs. O'Neill, the doctor holding some facts was necessary but not sufficient or, indeed, a priority for her, and she privileged this way of knowing over being known in a factual way.

This emphasis on the experience of the relationship in patients' accounts, of the doctor taking an individual interest in, caring about and having a commitment to the patient was common, as exemplified by the following data extracts:



Mrs. Peters: *'It's hard to put into words... just, you know, I see a light at the end of the tunnel if I know he's going to be there and I know he's going to help me... I feel that he's taking me through the different stages... he's there...'* (Mrs. Peters, PP 02-01).

Similarly:

Mrs. Quinton: *'... because you know this person sort of on a one-to-one... I do like her... You build up a rapport, and you understand one another...'* (Mrs. Quinton, PP 02-02).

A relationship between factual knowledge and interpersonal knowledge in patients' accounts was also present. Having an interpersonal connection was regarded as facilitating the presentation and accumulation of factual knowledge. It was said to encourage the patient to disclose factual information that might not have been given to a doctor with whom no such connection existed, as evidenced here by Mrs. Anderson:

RA: *'... it's interesting what you were saying about, you know, over the years, although you haven't had a huge amount of contact, that you do feel some kind of... [unfinished sentence due to interruption]'*.

Mrs. Anderson: *'I feel some kind of connection towards him.'*

RA: *'Right, and what do you think about that, do you think it's important or not for patients to feel a connection with their doctor?'*

Mrs. Anderson: *'Well, I would have thought so, yes, because I've experienced not having a connection with a doctor and you just tend to go in and say what's wrong with you and out the*

*door again, and sometimes you don't even repeat all your symptoms'* (Mrs. Anderson, MP 01-01).

Again, knowing in an interpersonal sense was often related to the higher standard of medical care in terms of the improved clinical outcomes that patients could achieve through the connection their with the doctor. However, the *experience* of the encounter was also emphasized, as evidenced by the regular reference to the patient's emotions when consulting a known doctor compared to one who was unknown.

### **Interpersonal knowledge: The Similarities between Patients' and Doctors' Accounts**

Doctors' accounts of personal care were equally characterized by what I have categorized as interpersonal knowledge. Indeed, it suffused doctors' accounts and was generally regarded as pivotal to General Practice as a profession. As discussed in chapter four, most doctors expressed having such an interpersonal connection with the patient as an essential component or a pre-requisite of personal care. To exemplify the way that doctors include interpersonal knowledge as part of how they know the patient, when asked what he knows about his patients, Dr. Ibsen commented:

Dr. Ibsen: '*... we've been through a lot of problems with that [ischaemic heart disease]... quite often there are other kinds of tentacles go out, you know... him and his wife are patients and his son and daughter are patients and their children are patients... and some of his grand-children go to the same school as my children, you know, so, it's all, sort of, contributing to your feeling of, of personal knowledge of that patient, and it's*

*all part of the bond, I suppose, of the relationship'* (Dr. Ibsen, MD 03-03).

It was also described as there being a connection between patient and doctor that was expressed, for example, as *'getting to know the patient in a close way'* and building a *'rapport'* (Dr. Abraham, MD 01-01) or having a *'bond'* (Dr. Gilmour, MD 03-01) with a patient, seeing the patient *'through thick and thin'* (Dr. Munro, MD 04-01), and as the patient and doctor *'liking'* one another:

Dr. Quick: *'... the third level, which you haven't mentioned, is the sort of personal relationship. You get on with somebody, you like them as people. There's a chemistry there...'* (Dr. Quick, MD 04-05).

Interpersonal knowledge was also expressed as the doctor's personal concern about, commitment to, and involvement with, the patient, the development of a therapeutic relationship and, also, as Dr. Wilson commented:

Dr. Wilson: *'... sharing something with the patient that cannot be shared with another doctor'* (Dr. Wilson, PD 03-01).

Similarly, the ephemeral quality of this way of knowing, compared to having factual knowledge, was further exemplified by Dr. Victor who talked about the patient and doctor knowing one another in this interpersonal way:

Dr. Victor: *'When you start looking at personal care, I suppose what you are looking at is an interaction between two people who know one another very well, without it being questioned every time you see them, and that provides a multi-faceted layer underneath...'* (Dr. Victor, PD 02-02).

As with patients', doctors' accounts were often expressed in emotional terms. Indeed, doctors discussed knowing the patient in this interpersonal way as what provides professional satisfaction and, at the same time, what places significant demands on their emotional resources. In short, interpersonal knowledge was articulated as the *raison d'être* of General Practice, the main attraction for these doctors to this particular branch of medicine, and, simultaneously, as what creates most occupational stress. Dr. Roberts had talked at length about the importance for him professionally of giving personal care, which he defined as having a relationship with a patient that involved such interpersonal knowledge. He expressed his concern that this might be lost in UK General Practice and be replaced by 'quick-fix' medicine. However, he also talked about the 'high costs' doctors can pay for such an interpersonal connection with patients:

Dr. Roberts: *'I can think of one patient I saw every few weeks for years who had a big drug problem and who could be incredibly aggressive, and he sometimes had to sit there until he actually burnt his aggression out... and I'd go home in the evening, I would feel completely drained, like he'd sucked out all the life-force out of you.... I don't know how to express that, really, because it's a personal resource that's drawn out of you in the process..., which is very satisfying as well... but, you also feel kind of burnt out, slightly'* (Dr. Roberts, PD 01-01).

Indeed, for doctors, as with patients, personal care was articulated as knowing and being known in a way that incorporates an emotional exchange and, for

doctors as the care-givers, this was described as being, at times, highly demanding of their personal resources.

## **Mutual Trust: The Patient Trusts the Doctor and is Known as Trustworthy**

Patients' accounts of *mutual knowing* were often intertwined with talk of trust. As outlined in Chapter Four, *mutual trust* was prominent in interviewees' accounts of personal care. It was expressed both as a defining characteristic of such care and as serving specific functions; as allowing the patient to have confidence in the doctor, and, of equal significance, to enable the patient to be known in a *particular way*. As with the above discussion of *mutual knowing*, when using the term *mutual trust*, I do not suggest the nature of the 'trusts' are equivalent, but that patients and doctors articulated this theme as relating both to the patient's trust in the doctor and to the trustworthiness of the patient.

Thus, personal care was recurrently linked by patients to having trust in the doctor. Referred to explicitly as trust and also as having '*confidence*' or '*belief*' and as feeling '*secure*', this was mentioned by almost all patients interviewed. Patient trust was conceptualized in two main ways: First, it was described as what I have called *de facto* trust; as that granted to the profession of medicine, and so to any doctor, due to having this professional status. For instance, Mrs. Ewan explained:

RA: '*Is that something you have always done? Have you trusted them [the GPs] from the beginning...?*'

Mrs. Ewan: *'It's just something, I go in and it's sort of like, well, the person is innocent until proven guilty, sort of thing. And that's the way I go in with my mind. That's the way I approach everything. With any person, professionals, I just treat them as innocent until proven guilty'*.

In these cases, trust was articulated as automatically being granted to all doctors, and only being removed if an event occurred which challenged the patient's perception of that individual practitioner. Mrs. Ewan continued:

Mrs. Ewan: *'Unless they prove otherwise, and then I'll just, em, if I feel that they have treated me, badly or anything like that, then, I just won't go back. I'll just say well, that's it. The customer service because I'm a customer, whatever it is'* (Mrs. Ewan, MP 02-01).

Second, trust in the doctor was conceptualized as what I have called *experiential* trust; as that arising and developed from having positive experiences of the doctor over time. *Experiential* trust arose from direct knowledge, both factual and interpersonal, of a particular doctor:

RA: *'So, what difference do you think it makes not getting your own doctor or someone from your practice?'*

Mrs. Anderson: *'You don't know how competent he is. I don't know this person from Adam, I don't know him or her. ... to me personally, I like to see Dr. Abraham [her own doctor], and I like to see the familiar face, and I know that I can trust him...'* (Mrs. Anderson, MP 01-01).

In this study, *experiential* trust is the predominant way patients talked about the trust they hold in the doctor. It was described as both an inherent feature of personal care and as a benefit of such care, due to knowing the doctor over time:

RA: *'So, what would you say for you that made it important that you had that kind of personal care...?'*

Mrs. Watson: *'Continuity, confidence in whom you're seeing, based on past experiences ... that's the main thing, just having confidence in your doctor'* (Mrs. Watson, PP 02-04).

Indeed, *experiential* trust is also described as developing in and through the relationship with the known doctor. In this case, Ms. Forrest was talking about the psychiatrists she consults at the hospital:

Ms. Forrest: *'I'd like to see the same doctor for a while, more than six months anyway...'*

RA: *'... so, why would you like them for longer? Why would that help?'*

Ms. Forrest: *'... they would know you and you would sort of build up a bond with them, learn to trust them and tell them things...'* (Ms. Forrest, MP 02-02).

Similar statements were made about the known GP. Again, emphasizing that trust was regarded as an essential component of personal care in the General Practice context, Mr. Inch stated:

Mr. Inch: *'... and that's why it's [personal care's] about the relationship, it's about trust and confidence, and so on, and it's*

*got to be on both sides ... it's [the relationship's] got to be built on trust'* (Mr. Inch, MP 03-01).

However, as indicated by Mr. Inch, trust as a feature of personal care was not only constructed as the patient trusting the doctor. Trust emerged as an important aspect of such care in another connected, yet distinctive, way; as the doctor's trust in the patient. This is also indicated by Mrs. Inch above who talked about *'trust on both sides'*. Mrs. Anderson further exemplifies how personal care was linked to the patient being known by the doctor as trustworthy:

RA: *'Is this the sciatica [a problem mentioned in the first interview and brought up in the second as causing pain] again?'*

Mrs. Anderson: *'Yes, so I would go to him for this but, again, if I couldn't get him it wouldn't be a problem unless I was crippled again. If it gets really bad I would probably go to him'.*

RA: *'And why is that?'*

Mrs. Anderson: *'Because he dealt with me last time, quick and fast and he gave me lots of pain killers and even said that I could phone up and have a repeat prescription and I didn't have to go in. So, obviously he trusted me, as well, to be responsible, because they were strong painkillers I was getting at the time. A lot of the time I slept because they were so strong. So, obviously he trusted me totally. He is not one of those doctors that said, "Don't bother me", because he knew, because you knew what you were doing' (Mrs. Anderson, MP 01-01).*



In the way patients mainly talked about trust in the doctor as being *experiential*, they also described the doctor's experience of the patient over time as forging her trust in the patient. For example, Ms. Nicols referred to the trust she accorded her doctor and, conversely, his trust in her. The interview continued:

RA: *'And do you feel you have that mutual trust situation with this practice?'*

Ms. Nicols: *'Yes'.*

RA: *'And is that something you feel you've had from the beginning...?'*

Ms. Nicols: *'No, it's something that's grown, I think... I think it's because they listen, they listen to what you say, and of course, when you first go to a new practice, they don't know me from Adam and, so, you can't trust somebody you don't know immediately. I think if they actually listen to what I say, and have an appearance at least of respecting what I say, then, em, if they do that, then that does two things, it reassures me that I'm not stupid and it also reassures me that they trust me, therefore I can trust them'* (Ms. Nicols, MP 04-02).

Indeed, seeing the known doctor was articulated as allowing the patient to be known as someone whose judgement of the problem is competent and, so, trustworthy. The doctor's trust in the patient was often related specifically to the patient's competence as a parent and, sometimes, to their 'expert' knowledge of their own child's health. The dialogue with Ms. Nicols continued on this particular point:

RA: *'So, is that important to you that, if you feel you need a service, that the service that you get is fairly prompt when you feel you need it?'*

Ms. Nicols: *'It is, yes, because one of the things that I think that's based on is the fact that the doctor has to trust me. I'm a parent and I know my children inside out, and I know if there's something wrong... so, I think that it's very important that the doctor has to trust my judgments... So, I think this trust, I feel if they trust me to know when I decide I think somebody should be seen by the doctor, then that also has to be reciprocated, if they say to me, "Oh, she's fine, just do this, do that, she's OK, don't worry", then I believe them, because the trust is a two way thing' (Ms. Nicols, MP 04-02).*

Seeing the known doctor was also expressed as allowing the patient to be known as trustworthy in the sense of the patient's claim to service being regarded as legitimate. The patient is known as one who only makes 'proper' use of the doctor's time:

Mrs. Mooney: *'... I like Dr. Neilson because (a) he knows that I'm not ringing up because I've got nothing better to do that day, which I think happens. I really only tend to ring up when I'm extremely concerned about the children... and I think a lot of people use GPs, well I know they do, they ring up because little Jimmy has got a cold... You [doctors] are dealing with people who, their diligence isn't great, or have little common sense... he knows I've rung up because I really mean it, it's because I am genuinely worried, not because I'm just wasting his time...' (Mrs. Mooney, 04-01).*

As indicated by some of these data, patients frequently made comparisons between themselves and others in terms of their competence as people and parents, and the legitimacy of their demand for service. They compared

themselves in these respects to those deemed incompetent and who were undeserving users of service. Such talk of patients overusing the system, putting pressure on GPs and, in the case of Mrs. Mooney, lacking in *'diligence'* and *'common sense'*, by implication, unlike herself, is common. Mrs. Ewan, in another such instance, stated that in her relationship with her current doctor she could be known as *'competent'*:

RA: *'... what way do they [the doctors] know you... what do they know about you?'*

Mrs. Ewan: *'... I just feel they know me... about my medical health, they know how competent I am...'*

RA: *'So, does that mean that they'd have to, if they're going to put you "in a direction that suits you" [reference to her own words], does that mean that they would have to really understand you as a person?'*

Mrs. Ewan: *'They would have to know about yourself, em, as a person... you have to give them respect as well ... I have seen it where there are patients have went in and they've been really abusive, and these kind of patients, they know that kind of patients... they know they patients, and they know they're just in there just to try and get what they want out of the doctors and abuse the system, and the doctors won't give these people an awful lot of time...'*

Without further prompting, she made a comparison between herself and those who are *'abusive'*. She explicitly connected being known as someone who is deserving of the service to being enabled to get the care she needs:

*'... but, at the same time, they'll give people like myself, who are maybe genuinely there for medical treatment, if and when they need it...' (Mrs. Ewan, MP 02-01).*

Similarly, the recurrent use of comparisons between how the interviewee and other, less 'scrupulous' patients are known is evidenced here:

*Ms. Vickers: '... it's the fact that somebody who knows you and believes you and can see that you're not, if you go to a GP that you don't know, they don't know if you are making it up, or exaggerating, and I have a sister who has never got anything wrong with her, and she's a chronic, "Oh, I've got a terrible headache, oh, I feel awful", you feel like saying to her, "There's really nothing wrong with you". It's not that there's nothing wrong with her, but she moans a lot about it, so I suppose the GP knows who's like that or who is quietly saying, "I've got a bit of a headache", and has actually got meningitis...' (Ms. Vickers, PP 01-03).*

This emphasis on being known as trustworthy was not only emphasized by the comparisons made between themselves and other 'incompetent' and 'malingering' patients, but also was articulated against a backdrop of patient awareness of the potential of they, themselves, being known 'negatively'. Patients recurrently and explicitly raised the spectre of being known in an unfavourable light themselves. For example, when Mrs. Ewan was discussing how her own doctors know her to be a competent and legitimate patient, she also talked about how they don't judge her negatively as a result of having a history of enduring mental health problems:

*Mrs. Ewan: 'They know a lot about me... I've been to, as an outpatient for psychiatric help... and they never, ken, bring*

*anything like that into it, eh... because they probably don't feel it's relevant to bring that up against me today'* (Mrs. Ewan, MP 02-01).

Similarly, Mrs. Inch, who had been explaining that her own doctor could trust her, then stated she had recently had an experience of being known in a negative way by one doctor, whom she did not know:

RA: *'So, for this woman doctor you were talking about there, did you feel from your experience of her that you were still getting personal care in the way that you would want?'*

Mrs. Inch: *'I didn't have a relationship with her... I mean, perhaps she thought I was being a hysterical mother, in which case she had me in the hysterical mother bracket...'* (Mrs. Inch, MP 03-01).

Patients' awareness of the possibility of being known negatively, and their related concern to ensure they are known in *a particular way*, is further strengthened by the emphasis placed on accurate note-taking. Mrs. Inch went on:

Mrs. Inch: *'...that speech therapist we were referred to... and she was wanting [her daughter] to say these words and, "No, no, [her daughter], I know you can say it and ...", and I sort of said, "Poor, wee darling", and the woman wrote in the notes that[her daughter]had an 'over-protective mother' (Mrs. Inch, MP 03-01).*

Similarly, the emphasis on adherence to the rules of patient-doctor confidentiality may be viewed as evidencing patients' concern to be known in *a particular way*:

RA: *'Do you think that's [confidentiality] important?'*

Ms Forrester: *'What, confidentiality? Oh, definitely. Oh, I wouldn't go if things I was going to say was going to get broadcast'.*

RA: *'Yes, yes, so when you go to see her, you know...?'*

Ms Forrester: *'If you have some very private problems, you don't want people to know'* (Ms. Forrest, MP 02-02).

Likewise:

Mr. George: *'... I feel OK about it [the doctor having full information about him] because it helps you in the long-term... and I know at the end of the day that it's not going to go any further. He might communicate it to another doctor for whatever reason, or put it in a note file, maybe. But ... I know that's going to be safe, its' not going to be leaked, it's not going to end up in any papers or anything like that'* (Mr. George, MP 02-03).

These two *experiential* 'trusts' - the patient's trust in the doctor and the patient being known as trustworthy - were sometimes articulated as having a symbiotic relationship: One was inextricably and necessarily linked to the other, if personal care were truly to be given. This lengthy, but illuminating extract from Mrs. Watson gives a flavour of this point:

RA: *'And you mentioned... earlier on when we started to talk... about this knowing and about the relationship, could you say something more about that, what do you mean about having a relationship with them?'*

Mrs. Watson: *'... this bit is very confidential, it's very private, but eighteen months ago my husband left, so there's just me and my two daughters. Now, this caused me a tremendous amount of pain and humiliation... and I told him [the doctor]... because he knew me, because there was this relationship because I had been in lots of times... he was able to reassure me that I wasn't going ga-ga... you do need this reassurance from people, especially when it's somebody that you know... and it's somebody that you trust... and I felt much better, just because the doctor, who I trust, had told me so...'*  
(Mrs. Watson, PP 02-04).

The trust she clearly feels she can have in the doctor, due to her experience of him in the context of their ongoing relationship, she then also connects to the trust he can, and must have, in her competence to identify 'signs' of illness, assess their seriousness and significance, and act appropriately:

RA: *'So, through having the relationship and having the trust that when he gave you reassurance, that was sufficient for you to go away and feel, you know, "I'm doing OK"?'*

Mrs. Watson: *'Yes, right... it probably worked both ways actually, again it was... my younger [child... she was vomiting violently, had a very strange purple rash and had a high fever... I rang the doctor, and this was in the evening ... but he came and he stayed here about half an hour... because obviously these symptoms were possibly meningitis ... the rash wasn't a classic meningitis rash... I've seen pictures of it, and it wasn't that... he had to make his own professional judgment, but I also think that he trusted me... When he left he said, "If she does get any worse, ring immediately, if she starts to get better then that's fine, but if she gets... any worse, ring immediately". But, I think if he didn't have that same level of trust in me, knowing that I knew what signs to look out for, I knew when my child was ill, he wouldn't have done that, he*

*would have made me whisk her off to hospital, you know, just to keep an eye on, but he didn't... but, I think it worked both ways, because I felt... he had to satisfy himself that it was OK to leave her...' (Mrs. Watson, PP 02-04).*

### **Mutual Trust: The Similarities and Differences between Patients' and Doctors' Accounts**

Doctors' accounts of *mutual knowing*, too, were often intertwined with discussion of *mutual trust*. Trust constituted a core component of their construction of personal care and as having the specific functions of enabling the patient to trust the doctor and to be known by the doctor as trustworthy. As with patients' accounts, doctors were usually referring to *experiential* trust, as many of the following extracts of data demonstrate.

Starting, first, with doctors' talk of the patient trusting the doctor, Dr. Quick had already stated that personal care involved knowing the patient. When asked what he meant by knowing the patient, he replied in reference to involvement in delivering babies and also to dealing with people with mental health problems:

Dr. Quick: '*... it's, you know, the relationship... it's very intense... an intense emotional relationship... a bonding experience... and trust, I suppose, is really what it's about...*' (Dr. Quick, MD 04-05).

Second, doctors paralleled patients' talk about trust as being mutual in nature. Doctors noted that personal care, where patient and doctor know one another and have established a connection, was characterized by the doctor being able to invest greater trust in the information given by the patient about the presenting



problem. It facilitated the doctor in knowing whether she could, ‘take [the patient] at face value’ (Dr. Franks, MD 02-03) or be able to judge how accurate a patient’s presentation of the seriousness of a problem is. In this latter respect, Dr. Lorimer compared an unknown patient from the out-of-hours service to one of her own patients:

Dr. Lorimer: ‘... I think it makes it much harder, much harder, you don’t know the people at all, you don’t know whether they tend to over-estimate things or under-estimate things...’ (Dr. Lorimer, MD 03-06).

Indeed, doctors noted that their response to, and treatment of, unknown patients was different to those they knew. In the case of attending known patients, doctors often stated they could interpret the patient’s presentation better due to having more information about them and also because they knew how much trust to place in what the patient said.

Like patients, doctors ascribed many significant benefits to *mutual knowing* and *mutual trust* as interlinked aspects of the meaning of personal care. These are the subject of Chapter Six on the importance and value of personal care. For now, however, it is noteworthy that both doctors and patients expressed such knowing as serving the specific purpose of the patient trusting the doctor and being known by the doctor in a *particular way*; as a trustworthy and competent person with a legitimate and deserving claim to service.

## The Need for Boundaries

Based on the analysis presented above, the patient and doctor knowing one another was seen as creating the context within which personal care could be provided. Personal care was commonly regarded as high quality care by patients and, so, the patient knowing and being known by the doctor, in the ways shown above, were considered to be positive.

However, patients' accounts also show that boundaries were placed around the knowledge they felt it was legitimate or appropriate for the doctor to hold. Patients described circumstances in which being known was unnecessary or, occasionally, even problematic. These boundaries were expressed in relation to both how the patient was known by the doctor and how the patient knows the doctor. Starting with how the patient was known, Ms. Campbell had already explained that she prefers to see her own doctors, whenever possible, because she knows them and they know her. However, she was quite clear about what knowledge it was legitimate and necessary for the doctor to hold:

RA: *'So, when you say, "they know your background" [reference to her own words], what is the kind of thing generally that you think is important for them to know about your background, what sorts of things?'*

Ms. Campbell: *'Just your medical records'.*

RA: *'So, like treatment they've given you in the past and medication and things like that?'*

Ms. Campbell: *'Yes'.*

RA: *'Do you think it's important for them to know about anything to do with your family, where you live or whether you're on your own or ...?'*

Ms. Campbell: *'Well, it's got nothing really to do with them really, it's really just your medical that they're interested in... It's none of their business really, about your family... there's like my mum and dad, it's got nothing to do with them, but... my daughter and my son, that's really important that way, but not like the other side of your family, they've got nothing to do with that doctor, so it's none of their business... I wouldn't mind if they asked about any of my other family, well, just like, "Is there any cancer?" I would answer that sort of question... like, the same with asthma... they asked if anyone else in my family had asthma. I said, "No", but anything else than that, they shouldn't' (Ms. Campbell, MP 01-03).*

Thus, knowledge appropriate for the doctor to know was commonly expressed as contingent. It was regarded as being on a 'need-to-know' basis and, usually, the need-to-know was related to the nature of a particular health problem:

RA: *'Would there be anything beyond your kind of medical history or the complaints that you have taken to them... that you feel that they do know or should know?'*

Mrs. Douglas: *'Em, no, I don't think that they do know... they may have a picture, but I don't think they have any factual knowledge about other things about you, like what you do, where you live, all those things, I don't, and I don't suppose there is any reason for them to know that unless it's a part of your, if you are depressed, if you have lost your job or something, then that becomes part of your medical problem but, otherwise, I don't think they need to know those thing... they would only ever ask if you had stress-related, high blood pressure or anything like that, they would probably ask if you worked full-time, but otherwise they certainly never ask you for*

*that kind of information ... yes, I don't, unless it is related, and I suspect that if you have a sort of mental illness problem, then all those things are relevant. But, otherwise, if it's a more physical or infection or something, then, I don't think it is'*  
(Mrs. Douglas, MP 01-04).

The problem-contingent nature of what patients stated their own doctor should know indicates the extent to which they were discriminating about the necessity and purpose of such knowledge in the patient-doctor relationship. Indeed, interviewees discriminated between those everyday health problems for which the usual doctor needed a minimum of contextual and personal information and those more complex or psycho-social complaints which justified wider and more personal information being held.

Patients' concern to maintain boundaries in the way they were known was also expressed in other ways. For instance, it was sometimes couched in terms of the potential dangers of knowing and being known by the doctor 'too well'. Specifically, these data suggest patients thought over-familiarity with the known doctor could result in her making assumptions about the patient and missing something of medical importance. For instance, Mrs. Kyle generally agreed that it was useful to patients to consult a known doctor, but then raised a possible disadvantage of being seen by a doctor who knows the patient well:

*RA: 'Do you think that they have, in that situation where they've built up a relationship with you, a sort of store of knowledge... that means that when you go, you don't have to be repeating?'*

Mrs. Kyle: *'I think that's true... but I think they have some knowledge of the sort of things you've suffered from and, therefore, they are in a better position to judge what you might be suffering from now. There is a danger in that though, too, that they may assume things... it could have a negative side as well, because if you've always had asthma and you go in and you're complaining of a chest infection, they may automatically assume that its due to your asthma... so there's pluses and minuses... they, sometimes, might know too much and they might read too much into things which may or may not be relevant'* (Mrs. Kyle, MP 03-03).

Mrs. Kyle went on to make the point that it can be useful to see an unknown doctor who can bring a fresh eye to the problem:

Mrs. Kyle: *'... I do think it is quite a good idea to see different people and you get different attitudes, different sorts of viewpoints'*.

RA: *'Why do you think that's a good idea?'*

Mrs. Kyle: *'Oh, well, I don't know, you know, there's really no right and wrong... doctors can make mistakes and different doctors can think of different things'* (Mrs. Kyle, MP 03-03).

Similarly, some patients expressed the problem of being known too well as causing greater embarrassment when dealing with personal or intimate problems. Patients particularly mentioned this as problematic for ailments, such as gynaecological complaints and pregnancy when the known doctor is male. Other instances included for cosmetic surgery on the stomach and for sensitive issues like having a sexually transmitted disease.

For instance, Mrs. Mooney, having explained she appreciates the benefits brought by receiving personal care, described the problem of consulting the known doctor about gynaecological problems:

Mrs. Mooney: *'... when I had my six week check with [name of child]... our second child, and he was, of course, meant to do it because that's what GPs do. I couldn't face it at all and I went in and he said, "Well, if you would like to now take your pants off", that sort of thing, and I completely lost it, I burst into tears and it was quite a nightmare actually... it was possibly because... I had got to know him better and, you know, I like him a lot, and probably that's what it was... and he is a fantastic doctor, but gynaecological things I would be hard pushed to go and see him... Now he has a female doctor... and I think that is a brilliant idea'* (Mrs. Mooney, MP 04-01).

In many cases, female patients stated that they would choose an unknown female doctor over consulting a known male doctor for some complaints.

Indeed, many female interviewees expressed similar feelings about attending the known (male) GP for gynaecological complaints. Ms. Nicols, who consults a single-handed, male practitioner, spoke with enthusiasm about her relationship with him, and was keen for him to have contextual knowledge about herself and her family in order to aid the quality of medical treatment provided. But, when asked whether there was anything she would not want the doctor to know about her, she replied:

Ms. Nicols: *'Em, things, well I go to the Well Woman Clinic, so things that are more personal in ways of a gynaecological, I would probably go to the Well Woman Clinic for, only because there is not a female GP in the practice. But, it's not the case of*

*wanting to keep information from the GP, it's more just uncomfortable'.*

RA: *'So, you go to the Well Woman Clinic for that reason, because it's basically Dr. O'Neill and Dr. O'Neill?'*

Ms. Nicols: *'I've nothing at all against Dr. O'Neill's abilities or whatever and you would think that, after having three children, you would just leave all your dignity at the door for anyone, but in actual fact I thought, no. In actual fact, you know I've been to Dr. O'Neill for smears and things, but I go to the Well Woman now' (Ms. Nicols, MP 04-02).*

Thus, the combination of knowing the usual doctor so well, together with his gender, were said to preclude several patients from submitting to an internal examination being undertaken by him.

In a few cases, patients felt that knowing the doctor too well could be problematic in circumstances where they would value anonymity. Again, this was expressed as relating to those situations deemed embarrassing or of an intimate nature. For example, in response to whether she would consider using NHS Direct or an NHS or private walk-in-centre, Ms. Leishman stated:

Ms. Leishman: *'I would use the NHS Direct... I would imagine that you don't get personal care because I would imagine that you wouldn't see the same one each time you went, it was just who happened to be in. It could be useful for something where you wanted to be anonymous, if you, I don't know if you had a sexually transmitted disease or something you didn't want to go to your practice, I can see that there is a function for that sort of thing. And, equally, for me, if there was anything like that that I didn't want to go to my GP for I would go to the Well Woman Clinic which is NHS... yes, I can*

*see that for some things. Not wanting it to be on your notes for whatever reason. Especially if your whole family goes to the same doctor, even if you thought there was confidentiality, you might over something like that, there are cases of things, hopefully nothing that would happen to me, but you might want anonymity...' (Ms. Leishman, MP 03-04).*

Likewise, patients placed firm boundaries around how they know the doctor. They talked about the need for limits around how patient and doctor know one another beyond factual information to include knowing in an interpersonal and social way. Whilst most patients valued seeing a known doctor and emphasized the benefits of this, patients were concerned to preserve an appropriate 'distance' in the relationship. For instance, Ms. Leishman had talked about the close relationship she enjoys with her own doctors. She went on, however, to spontaneously emphasize the social distance that is imperative to her in her relationships with her GPs:

*Ms. Leishman: '... I think actually I would feel uncomfortable about seeing a doctor that I knew as part of my social life... I think I would find that too personal'.*

*RA: 'Right, that's interesting'.*

*Ms. Leishman: 'Yes, in fact we have a GP who lives [close by] and, em, I think twice in five years that we've lived here that I've asked him to come up or have taken one of the children down to look in their ears or something to avoid me having to go to [name of out-of-hours service], but I would never ask him anything to do with myself'.*

*RA: 'Right. What do you think that's about?'*



Ms. Leishman: *'Em, well, while I fully expect that he or any other neighbour or friend would be totally confidential about things... but, I would feel uncomfortable about... undressing in front of him, even in a professional, you know, even in a surgery, em, as opposed to in his flat or my flat. Em, I would feel uncomfortable walking around knowing that he had seen me, em, and undressing mentally as well, you know, I wouldn't feel, em, I wouldn't want to tell somebody that I knew that well, my problems. No, having a bit of distance is a good thing'* (Ms. Leishman, MP 03-04).

The need to maintain such a social distance was also highlighted by Mrs. Mooney, who appreciates the personal care she receives from her single-handed practitioner, but with the following qualification, shown here, about how close the relationship with her doctor should be:

Mrs. Mooney: *'So, yes, familiarity I suppose is good. But yet, I would **never** choose a doctor who I knew as a friend, personal friend. **Never**'* [her emphases].

RA: *'OK, why is that?*

Mrs. Mooney: *'Because I don't really want to go to a party and know that Dr. whatever had seen my nether regions or whatever, it's just too close, unprofessional'* (Mrs. Mooney, MP 04-01).

One final recurrent issue that emerged from these data on the theme of the boundaries patients place around knowing relates to how the patient is known by the practice as a whole. In this sense, it is not relevant to the finding that knowing and being known was central to how patients mainly constructed personal care; that is, in terms of the relationship with one or a small number of

doctors. However, it does illustrate further the extent to which patients were discriminating about how they are known.

Indeed, boundaries of knowing were also often articulated with regard to practice staff other than medical practitioners. They were particularly emphasized in relation to receptionists, who were deemed by many patients to have no right to any information or, at most, to minimal, non-personal information. Indeed, reception staff holding or requesting personal information was a source of irritation to many patients in this study. Mr. George, although generally positive in his comments about the care from his practice, complained the reception staff asked for personal information inappropriately:

Mr. George: *'The worst staff up there are the receptionists, to be perfectly honest, I'm not keen on their approach at all. At times, I could quite easily fall out with them. Em, I sometimes think they ask more questions than is necessary, some of the questions, at times, are on a personal level, which have really got nothing to do with them'* (Mr. George, MP 02-03).

Similarly, Mrs. Peters felt it was inappropriate to provide certain kinds of information to reception staff:

RA: *'So, when you phone up and you get the receptionist, you're quite happy with them?'*

Mrs. Peters: *'Yes, yes, most of the time, apart from, you know, if you say you want a doctor, sort of today, and they say, "Well, what's wrong, like?", and you've got to explain to the receptionist what's wrong with them...'* (Mrs. Peters, PP 02-01).

Thus, knowing and being known were articulated as key characteristics of personal care and as benefits of such care. However, this was not an information free-for-all. The extent and type of knowledge the doctor should hold was described as being contingent upon the nature of the problem, some more intimate problems were kept from the known doctor and boundaries were placed around the relationship in social terms.

### **The Need for Boundaries: The Similarities and Differences between Patients' and Doctors' Accounts**

Paralleling patients' accounts, doctors also did not think that *mutual knowing* was without limits and entirely unproblematic. However, the extent to which the patient should be known as a matter of problem-contingency did not come out as strongly as in patients' accounts. A few doctors did state that the level and type of knowledge they need to have about a patient is linked to the nature of the problem. For instance:

RA: *'OK, and what sort of wider knowledge that you're talking about... do you think it's important for you to know?'*

Dr. Lorimer: *'Em, it depends a lot on what somebody's problem is. You know, most medical things, you don't need any wider history, but for a lot of, you know, depression or, I mean, even a lot of physical symptoms, probably is tied up with a lot of what else is going on, em, things with their family or, you know, if someone died or other things about them that might be important'* (Dr. Lorimer, MD 03-06).

However, as Dr. Lorimer also indicated, most doctors perceived that contextual knowledge was important for the interpretation of many symptoms. Likewise,

many doctors thought that such information was important, regardless of the patient's problem. Indeed, doctors regarded the building of knowledge of the patient through contact over instances of minor, self-limiting illness to be as important as it is for complex, serious and long-term illness. Distinct from patients' accounts, *mutual knowing* was described by doctors as having an investment function, a 'banking' of knowledge and experience over time that would be important in the event of the patient developing a chronic, complex or life-threatening illness at some point in the future, which would require personal care.

Thus, whatever the nature of the presenting problem, building a relationship between patient and doctor, was considered to be time and effort well spent in preparation for when more intensive personal support from the doctor may be needed. For example, in defining what personal care means to him, Dr. O'Reilly stated:

Dr. O'Reilly: *'... am I building a knowledge of the patient and their life and their health? And that starts with factually recording elements about patients, which I was taught by my trainer... subsequent consultations may build a picture of families or recurring patterns of presentation, fragility, early indication of disease... so, it's curiosity that informs the way in which I consult, and then the information may provide a very helpful base from which to deal with more complex problems. So, even if a new patient or a temporary resident comes in and presents a life crisis, I find it an economy in time just to sit back and say, "Well, look, I can't deal with this without knowing a bit more about you. Can I just run through these questions that I use in these situations?"'* (Dr. O'Reilly, MD 04-03).

Similarly, providing personal care to those with minor and self-limiting problems was regarded as an investment in the patient in another sense. It was expressed as facilitating the patient to open up about complex issues already in existence, but at a time the patient feels she can disclose such information. For instance, Dr. Emmerson had explained that personal care was most important for those patients with psycho-social and more complex problems. However, he continued by saying that he does try to make himself open to everyone who consults him, to put himself *'in a position where [he] can receive confidences'*. He described this as the patient coming to see him:

Dr. Emmerson: *'... like a dog sniffing at the lamppost first... to see how you deal with them, see if you're right the person, and whether you sound caring or not and, so, you get one or two little consultations for minor things'* (Dr. Emmerson, MD 02-02).

Like patients', doctors' accounts of boundaries were often couched in terms of the dangers that could result for both patient and doctor if these boundaries were breached. For instance, the patient and doctor becoming 'too familiar' was expressed by doctors as potentially problematic for patients. It was typically believed that this could result in the doctor having a *'narrow'* or *'complacent'* view of the patient, pigeon-holing and making a judgment about her based on previous experience of the patient directly or through having contact with her family. For instance, one doctor noted that *'familiarity can breed contempt'* (Dr. Harris, MD 03-02).

It was also expressed as the doctor making assumptions about the patient and coming to a wrong diagnosis and, further, the patient becoming dependent on the doctor and over consulting, as a result. For instance, referring here to personal care, and specifically to the doctor knowing the patient, Dr. Strong commented:

Dr. Strong: '*... I mean I think it can go against you. I do, I think sometimes you can get stuck with patients and, you know... I think you can get a fixed view of people which may not be true. You can, you may develop an idea about somebody's symptoms which is wrong...*'.

RA: '*... when you say "stuck", do you mean dependency?*'

Dr. Strong: '*Well, no, you can get stuck in a dependent relationship, but I think you can also get stuck in a wrong view of a problem, but dependency I think that's a big issue for small practices, too*' (Dr. Strong, PD 01-02).

Similarly, Dr. Gilmour had talked at length about the special place of personal care in General Practice and as it being the reason he chose this area of medicine in particular. He then commented on the problems that *mutual knowing* can bring:

RA: '*... do you think it's [personal care's] equally important for all your patients, in terms of your definition?*'

Dr. Gilmour: '*... it has its drawbacks sometimes, because you can make such patients sometimes over-dependent and over-reliant, and rather than equip them to manage their lives as well as they can, all your doing is allowing them to allow you to manage their lives as well as you can... it is open to criticism, and the over-dependence aspect and making life more*

*burdensome for you, and making the patient more dependent, all of those are factors that could make this fall apart...*' (Dr. Gilmour, MD 03-01).

These '*over-dependent*' patients were frequently referred to as '*heart-sink*' patients and were described as being problematic for the individual doctor. Indeed, as Dr. Gilmour illustrated, dependency was thought to be problematic not only for the patient but also for the doctor, and this was regularly expressed as being personally demanding and using the doctor's resources to the point of 'burnout':

Dr. Emmerson: '*... so you have to get the balance right between, em, being interested and wanting to help people, whilst not becoming so involved in their crises that it uses up something of you*' (Dr. Emmerson, MD 02-02).

Many doctors did concur with patients that *mutual knowing* should be subject to certain parameters in other respects. Whilst a few doctors talked about being '*friends*' with their patients, as outlined earlier, most emphasized the importance for them in maintaining a professional-patient boundary:

RA: '*Is there anything else that springs to mind about personal care...?*'

Dr. Clarke: '*Just, well, it's important to remain professional in the level of care you're offering and if patients are sort of happy with their personal care, but think that means they can come every week for a chat, then, you know, that becomes difficult. So, you have to maintain a professional standing, but open enough to the patient to let them feel they can be open to you, but have very, obvious, em, what's the word, I can't think,*

*boundaries will do, yes, to try to keep the behaviour as appropriate...*' (Dr. Clarke, MD 01-03).

Indeed, placing boundaries around how the patient and doctor know one another was expressed in relation to the extent to which the patient should know about the doctor's family and personal circumstances. Whilst some doctors stated that they used reference to their own circumstances in consultations, they also placed boundaries around the extent to which this was done.

A related issue of concern, that was only present in doctors' accounts, was that they would, at times, sometimes avoid seeking or being receptive to information about patients. For example, on 'difficult' days, they said they would not pursue opportunities to develop their knowledge of the patient and, in fact, deflect patients' attempts to raise previously 'hidden' and painful facets of their private lives:

Dr. Lorimer: *'You know, occasionally, I guess you're in the situation where they've probably been there for twenty minutes already, and they raise something else, and you sort of think, "Oh, I'm not going to get into the whole thing", so, you deal with it on a very superficial, and you never feel good about that...'*

RA: *'And would that come up because of pressure of time, would it?'*

Dr. Lorimer: *'Yes, mostly, yes, or else if they're someone else's patient and you kind of don't want to open up a whole can of worms, but mostly pressure of time, if they've been there for ages about other things'* (Dr. Lorimer, MD 03-06).



The specific reference to doctors being resistant, at times, to '*opening up a can of worms*' was common across doctors' data.

Finally, like patients, doctors talked about placing boundaries around how patients are known in other ways. They questioned, for instance, the extent to which confidential information should be shared with other staff members or included in patients' records. They paid attention to the tensions and conflict of interests presented by holding personal and intimate information about different members of the same family and raised the problem for patients of there being, generally, less anonymity when receiving personal care:

Dr. Abraham: '*... there are one or two [patients] you meet, who are very keen not to share, particularly elderly people who don't want their family worrying about them. They know that their health is getting a bit less good, they can't do as much or they've got some illness which they think is fairly serious and their family is worried about them and the family want to discuss it, these are very difficult, yes. When they want information and you want to give personal care to the whole family, particularly if they are patients of yours as well, but you don't want to give away much information*' (Dr. Abraham, MD 01-01).

## **Mutual Knowing and Mutual Trust in Personal Care: Practice size and Deprivation Score**

As expected, patients and doctors' accounts of *mutual knowing* and *mutual trust*, as composite features of personal care, show the same variation by practice size as the construction of meaning of the overall concept. In short, patients from

single-handed practices talked, as would be expected, about these themes in relation to their one GP. Patients from small practices tended to talk about *mutual knowing* and *mutual trust* in relation to all of the two or three practice partners. The exception to this was when the patient faced a particularly complex, chronic and serious condition, in which case one doctor was usually designated the personal doctor, at least over the episode of care. Patients from large practices tended to talk about knowing and being known by one, occasionally two, of the six practice partners. Generally, there were no such differences identified between practices in terms of the detail of what was known, the function it served, or the boundaries placed around it.

One other difference noted is that it was more common for patients from small practices to be aware of doctors' special interests or areas of expertise or which doctor would be best suited to dealing with a particular type of problem. As indicated earlier, for example, one doctor from a small practice was said to be good at sports injuries, whilst another (the female partner) had most experience in dealing with gynaecological problems. The 'sports injury' doctor was also described as being known as someone who could best deal with the 'softer' issues of family relationship problems:

Mrs. Thomson: '*... for any sort of muscle type injury, sort of sports injury type of thing, I think I would tend to go to see Dr. Roberts because, from experience, I've found he's very good on that particular thing. I would possibly go to see, well, obviously for smears and that Dr. Strong does most of that work. I would possibly tend to go and see her on sort of "women's problems", if you like, not necessarily, but it sort of*

*comes with the way the practice is divided up, I think'* (Mrs. Thomson, PP 01-01).

In the doctors' data, no differences by practice size were found in how they talked about *mutual knowing* and *mutual trust*.

In relation to the deprivation score of the practices, the construction of the meaning of personal care generally is found to show no variation in either patients' or doctors' data. However, there is some difference by deprivation score in how doctors talked about the means by which they gathered information on patients, and on the function it serves. In deprived practice areas talk about *third party* information was more prominent. This was gathered through, for example, reception staff living in the area or knowing the patient or her family personally more than was evident in the affluent practices. Further, compared to affluent practices, there was relatively more emphasis in doctors' accounts on detailed information, obtained by any means, serving to monitor, control and manage the 'problematic' patient. No differences were found in this respect in patients' accounts.

## **Summary and Discussion**

In this chapter, I have presented data on the themes of *mutual knowing* and *mutual trust*, which in the last chapter were shown to be key characteristics of what constitutes personal care in interviewees' accounts. These important themes did not arise from pre-set research questions, but emerged out of data analysis. They lend further support to many of the points discussed in Chapter

Four. Again, the similarities between patients' and doctors' accounts in these two respects are striking.

The data show that interviewees talked about *mutual knowing* in two ways; what I have called factual knowledge and interpersonal knowledge. Factual knowledge related more to the patient or doctor holding facts, whilst interpersonal knowledge was distinguished from this by placing an emphasis on the *experience* of the relationship; a 'human connection' between patient and doctor that was often expressed in emotional terms. The finer detail of what interviewees meant by *mutual knowing* provides further evidence of how they invoked and drew upon a bio-psychosocial discourse of medicine when discussing personal care. The data show that patients accepted, and indeed often expected, the GP to hold information about their individual biography, family health status and wider domestic and social circumstances, and that an interpersonal connection could and should be made. Further, the doctor, like the patient, was constructed as a sentient human being whose clinical skills, including any particular medical expertise, general consultation style and some aspects of personal biography, were legitimate areas of knowledge for the patient to hold.

However, the data also demonstrate that interviewees did not talk about personal care unproblematically. Boundaries were placed around how the patient and doctor should know one another. For most patients, the doctor's legitimate sphere of knowledge about them was contingent upon the nature of the problem. It was discussed as being on a need-to-know basis. However, this

was not a prominent aspect of doctors' accounts. Rather, they emphasized the 'banking' function of consultations. Thus, consultations even for minor, self-limiting illness offered an opportunity to accumulate knowledge of the patient and for relationship building that would be an investment for the future. Doctors placed limits around the extent of information the patient should hold about them, and most interviewees, patients and doctors alike, also placed boundaries around how they should know one another socially.

Thus, the data demonstrate that personal care was not regarded as inherently positive, as many working in this field previously have hypothesized or assumed by testing some conceptualization of care with a personal component against outcomes or equating it to a proxy measure of quality care (Flint *et al.* 1989; Baker and Streatfield, 1995; Baker, 1996; Love *et al.*, 2000). The potential dangers of personal care were noted in both data-sets as; being known '*too well*', with over-familiarity leading to the doctor having a narrow view of the patient, making judgements, misdiagnosis and, in doctors' accounts, to 'over-dependency' on the doctor. Patients also noted they could be discouraged from consulting the known doctor about a problem deemed too embarrassing or intimate, and this was particularly noted as an issue of gender. Many doctors commented that a major dis-benefit of providing personal care was the stress it could bring for them. Indeed, doctors, simultaneously, regarded personal care as their vocational *raison d'être*, the source of their occupational satisfaction, but also what places considerable demands on their personal resources and causes them occupational stress.

In Chapter Four, I also showed that care from a known doctor was insufficient in itself to constitute personal care. For care to be personal, the doctor had to show a specific consultation style and, usually, there had to be an interpersonal connection between the two parties. Likewise, in the data presented in this current chapter, the emphasis is on the importance of the qualitative experience of the relationship, the interpersonal *way* in which one knows and is known.

Practice size is found to influence how patients talked about *mutual knowing* and *mutual trust*. As shown in Chapter Four, those from small practices tended to discuss this in relation to all the GPs in the practice, whilst in large practices they tended only to mention one, possibly two, GPs. Patients in smaller practices appeared to know more about the medical expertise of all practice partners compared to large practices. Doctors talked about how they gathered information more than patients did, and doctors from deprived practices placed greater emphasis on *third party* information than those from affluent practice areas. Doctors also discussed gathering information by all four means identified (*information seeking, information offering, third party information and official information*) as an effective way to monitor, control and manage the 'problematic' patient.

*Mutual knowing* has been a central, though implicit and conceptually unexplored, feature of much previous research. In the health and satisfaction outcomes literature outlined in the literature review, for instance, continuity of carer has been conceptualized and operationalized mainly in terms of the duration and frequency of contact (Flint *et al.*, 1989; Kaplan *et al.* 1989; Hodnett

*et al.*, 2000). Recognizing that a temporal measurement may not necessarily give an indication of the quality of a relationship, other studies have taken account of the doctor's prior knowledge of, and sense of responsibility toward, the patient. Likewise, they have taken account of the patient's assessment of how well she feels she knows the doctor, when operationalizing this concept (Hjortdahl and Borchgrevink, 1991; Howie *et al.* 1999). A few studies have also considered how accumulated knowledge over time impacts on the process and experience of care when interpreting their findings of a positive association between continuity and improved outcomes (Gulbrandsen, 1997; Love *et al.*, 2000). The data presented in both these chapters support the need to incorporate more experiential elements of care in future research on personal and continuity of care. Many of these aspects are unquantifiable and may only be understood through a qualitative methodology.

*Mutual knowing* was shown to serve the function of promoting *mutual trust* between patient and doctor in both sets of accounts. The main way interviewees conceptualized trust when talking about personal care was as what I have called *experiential trust*; as that invested in a particular doctor through experience over time, rather than being automatically granted to the medical profession as a whole. The evidence of these data supports the contention that having faith in a medicine has continuing relevance for patients in the modern UK NHS. This finding concurs with the empirical work of Lupton (1996), who also concludes from an Australian study that:

*'... even when people acknowledge the uncertainties around medical treatment and the possibility of negligence on the part*

*of doctors, many are still reluctant to relinquish their faith or trust in medicine'* (Lupton, 1996: 162).

Lupton explains this as emanating from the need for patients to manage uncertainty. I will discuss in the next chapter that personal care, and trust as a core feature of that care, was said to be most important when suffering from serious or life-threatening illness, where the problem is ambiguous or complex in nature and, generally, for problems that have high emotional salience. The need for continuing faith in the doctor was linked to supporting patients to deal with the uncertainties that ill-health and health care-seeking and –receiving can engender.

In this chapter, I have also shown that *experiential* trust was not only discussed as relating to patients' confidence in the doctor. The concept of trust was also articulated as enabling patients to be known in a *particular way*; as trustworthy and competent parents and patients with a legitimate and deserving claim to service. Patients worked hard at being seen in this way within the interview context and used the rhetorical device of referring to 'undeserving others' in order to stake their claim to this particular moral identity. Indeed, as Lupton concludes from her empirical work:

*'... trust is required on both sides [of the patient-doctor dyad]'*  
(Lupton, 1996: 165).

The emphasis on the patient being known in a *particular way* may be understood in the context of an organizational and cultural background that constructs patients as potentially problematic. Literature abounds on the problem of the



*'demanding patient'* (May and Kelly, 1982; 1991; O'Dowd, 1988; Fineman, 1982; Rogers *et. al.*, 1999). These data suggest that personal care facilitates patients within this context to negotiate a path through a complex, morality suffused health care system, to obtain the care they deem necessary and, more generally, to manage the experience of illness in the family.

# CHAPTER SIX

## The Importance and Value of Personal Care

*'... if it was to do with a lump in my breast, or something like that, I think I would prefer to go and see [my own doctors] because that's the two I'm really close with... if I found a lump on my breast or if I felt I was having a miscarriage or something... But, if it was just a case like, well, I've got back pain or something, then, I would go to any doctor, you know. If it was something more personal to do with myself or to do with depression, or something like that, then I would prefer to see my own doctor' (Mrs. Ewan, MP 02-01, 2000).*

### Introduction

In this chapter, I deal mainly with the study's second research question; *what importance and value do patients and doctors place on the concept of personal care in General Practice, and in what contexts?* These data, therefore, arose mainly from asking pre-set research questions.

The data show that patients and doctors placed significant importance and value on personal care, and attributed numerous specific benefits to it. These benefits related to two main themes; the *experience of seeking and receiving health care* and the *quality of care* provided in terms of *medical outcomes*. However, seeing a known doctor was not considered important in all circumstances, nor was it universally applied. Patients identified situations where this was of greatest value, others where it was traded-off against competing priorities and

some where it was deemed completely irrelevant. Patients and doctors noted that personal care could be potentially problematic, and, sometimes, even disadvantageous. The perceived need for personal care varied according to a given health problem and was contingent on patients' view of the particular circumstances at hand. The importance and value ascribed to personal care was, therefore, *context-dependent*.

Doctors' accounts of the importance and value of personal care were strikingly similar to patients', with only a few differences noted. The comparison of these similarities and differences are discussed at the end of each main section. No differences are identified in relation to practice size in patients' or doctors' accounts of the importance and value of personal care, except that patients' trading-off activity was said to be greater in large practices than small. In terms of deprivation score, the only difference identified is the greater emphasis placed by doctors from more deprived practice areas on the benefit of personal care in controlling and managing the, so-called, problematic patient.

The importance and value attributed by interviewees to personal care are discussed in light of relevant research, which I outlined in the literature review.

## **The Experience of Seeking and Receiving Health Care**

Generally, personal care was said to have significant importance and value in terms of the patient's *experience* of health care in both the process of seeking health care and when receiving it. The patient knowing the doctor allowed her to predict the doctor's response. This was discussed as important to the patient

when making the decision to consult and during the consultation itself. Such knowledge was explicitly articulated as being based on 'experience' of the doctor over time:

Mrs. Brown: *'I just know the way he is and the way he is going to be and, just through past experience I know how he's going to react'... he talks to you like a normal person, he calls you by your first name... and he knows the kids... and he knows them by name... and he talks to you on a level... I can go up to him and know for a fact that he won't fob me off... I've never once in all these years went up and he's been in a mood, never once...' (Mrs. Brown, MP 01-02).*

Personal care was attributed with ameliorating the experience of difficult emotions that deciding to consult and being at the consultation can sometimes elicit. For instance, in relation to making the decision to seek care, Ms. Leishman had already given a detailed account of a recent unsatisfactory experience with the out-of-hours service, when unknown doctors had attended her. She compared this negative experience to that with her own doctor, and connected this to reducing such negative emotions:

Ms. Leishman: *'... and he just has a lovely way with children and he never makes you feel like you've gone for nothing... yes, he just makes you feel you haven't wasted anyone's time by going. I think that's probably, you don't feel uncomfortable about it [going to the doctor]...' (Ms. Leishman, MP 03-04).*

Ms. Campbell made the same comparison of her experience between known and unknown doctors, once at the consultation:

Ms. Campbell: *'I feel comfortable when I do go to those two doctors [her known doctors]. But, if I go to another doctor, eh, you know, I feel uncomfortable. Like, quite a few times I've had a different doctor, eh, I felt uncomfortable, "What can I say to them, like?" But, with they doctors, I just sit there, go in, just sit comfortable and get really comfy. I feel comfortable with they doctors, but with the other doctors I just dinnae feel comfortable'* (Ms. Campbell, MP 01-03).

The negative emotions cited include experiencing discomfort, anxiety, fear and panic. These were said to pertain in many situations, but mention of them was particularly prominent when interviewees were discussing their own chronic health problems and those of their children. Mr. Hendry was talking here about his step-son who suffers from severe bouts of asthma, about which both parents expressed great concern:

Mr. Hendry: *'That's if we get the same doctors ... if you get a different doctor, you go, "He's wheezy", that's it... or you are so uptight because you are, so panicky. Where, if you get your normal doctor, you can relax and go, "Right, this is what has happened..."'* (Mr. Hendry, MP 02-04).

Personal care was also expressed by patients as impacting on what they feel able to consult about and to encourage patient consultation. Mrs. Anderson had already commented that she would choose to consult about more 'minor' ailments with a known doctor compared to someone unknown. She then went on:

Mrs. Anderson: *'Generally, I'd go, I think I would go to him for more minor things and not feel that I was just being a pest'* (Mrs. Anderson, MP 01-01).

Indeed, typically patients stated knowing the doctor not only meant they would consult about more 'minor' problems, but also purely to be reassured about a health or related matter:

RA: *'You haven't had any particular health problems or any crises in your health? Is there anything that's particularly worried you?'*

Mrs. Quinton: *'Not particularly, no... Everybody has their ups and downs, I think just going and speaking to this person... it will make you weather whatever you're maybe feeling... something that's maybe worrying you, you just go along and say what has been worrying you, and it's probably nothing at all...'* (Mrs. Quinton, PP 02-02).

Patients also suggested knowing the doctor widened the parameters of what they felt able to consult about to include problems of a more personal or intimate nature. Mrs. Peters was asked to give an example of a time when she had received personal care. She replied:

Mrs. Peters: *'I think probably when I lost my dad, when I was expecting the youngest one, my dad died. Well, I fell pregnant in the November, and my dad died with cancer in the December, within a week, it was very, very, quick. I found that very, very hard. I found Dr. Ure was very good... he, you know, tried to explain to me, although my dad lived up North, he didn't know my dad, he was very good at trying to explain what probably went wrong with my dad. He was just very, very good.'*

RA: *'And did you go to see him so that you could just talk to him about what had happened, because you were upset?'*

Mrs. Peters: *'Yes, I was crying. I was in an awful state, and I found he was very good there, he was very supportive'* (Mrs. Peters, PP 02-01).

In this case, Mrs. Peters consulted the known doctor in order to help her come to terms emotionally with her loss. Similarly, Mrs. Brown related that knowing the doctor meant she immediately consulted her when feeling under excessive emotional strain, having just *'slapped'* one of her children *'hard'*:

RA: *'Right, so you're quite happy with Dr. Benton. And, what was she like then, was she similar to Dr. Abraham?'*

Mrs. Brown: *'... I had like, em, emotional problems once... marital problems and depression and stuff like that. Do you know, I went to her one day and I like I confidentially told her, I said that I was really cracking up at the kids, I was so depressed and I was in the shops one day and [her son] didn't even do anything and I slapped him so hard and I thought, "What am I doing?", and I just got into my car and drove straight up to the doctor's surgery and I told her, and I said "Do you know what I just done an hour ago? I can't believe I just done it, I slapped him so hard, I feel like I could murder them sometimes, I'm so depressed and upset", and I was in there for about an hour and she like, really listened to me and I was like crying and she was really, really good...'* (Mrs. Brown, MP 01-02).

Notwithstanding those situations noted in Chapter Five, where seeing an unknown doctor for some personal problems was preferred, typically, knowing the doctor was perceived to facilitate patients being able to speak more freely about difficult, painful or embarrassing issues once at the consultation.

Personal care was also said to impact positively on how patients behave in the consultation, mainly by encouraging their participation. Knowing the doctor ameliorated the experience of difficult emotions sometimes associated with seeking and receiving health care and, so, supported patients to relate their symptoms more fully, ask more questions and be more open about a problem. Again, patients typically compared seeing a known and unknown doctor. Ms. Hamilton had already stated that it was more difficult to talk openly to an unknown doctor:

Ms. Hamilton: *'A lot of people feel like that [afraid of the doctor]... they are not explaining what is wrong with them, not giving their full symptoms'* (Ms. Hamilton, MP 02-04).

Patient trust in the known doctor was also said to impact positively on how the patient felt about the diagnosis and prescribed treatment. Here, Ms. Jackson explicitly talked about how she experienced these encounters:

Ms. Jackson: *'... ideally, they would know you, and recognize you coming in, and, oh yes, they'd have some sort of recollection of your history... '*

RA: *'Yes... where you think you get a sort of family doctor, what do you think the advantages are?'*

Ms. Jackson: *'Just a bit of, just a bit of security, security is not the right word, just the comfort factor really... and, as I said, the sort of confidence thing... Just the feeling of confidence in them and trust'* (Ms. Jackson, MP 03-02).

Patients' experience of seeking and receiving health care were also reported to be positively affected in a more practical sense by personal care. It facilitated



the patient to gain speed of access to a particular doctor, when deemed necessary, and was articulated as using the known doctor's authority with reception staff to obtain a quick appointment:

Ms. Campbell: *'She's always had problems with her ears ever since she was born, and I kept going to the doctor, and Dr. Abraham turned round and said to me, "Any time you have problems with her ears, and you can't get an appointment, just come and say that I said that". So, I'll get an appointment that day'.*

RA: *'Because you've said ...'*

Ms. Campbell: *'Because I always say, "Dr Abraham always says that I've to get an appointment straight away", which I always do' (Ms. Campbell, MP 01-03).*

Once at the consultation, personal care was considered to save the patient time and effort, because the shared, assumed level of knowledge existing between patient and doctor means patients do not have to repeat their story:

RA: *'Do you think there was an advantage in you keeping seeing the same doctor about the one thing?'*

Mrs. Brown: *'Yes, yes. I think there is, because you're not having to start again from how you feel, you've already said how you feel to this one and you'll go back and she'll sort of say to you, "Well, how do you feel now, do you feel any better on the tablets?". So, she knew what you were going through at first and, then, so you'd go back' (Mrs. Brown, MP 01-02).*

Thus, patients generally talked about personal care in terms of their *experience* of health care. It was described as impacting on what they could anticipate in

advance about the consultation and how they experienced it once there. Reference was frequently made to knowing what to expect, which reduced uncertainty and the negative emotions that can attend making the decision to consult and when actually consulting the doctor. However, the benefits of such care were articulated as being important, not just for their own sake. They were also expressed as helping patients to obtain high *quality medical care*. Improved quality of health care in terms of *medical outcomes* constitutes the second main category of importance and value patients placed on personal care.

### **The Experience of Seeking and Receiving Health Care: Similarities and Differences between Patients' and Doctors' Accounts**

Doctors discussed the benefits of personal care in very similar ways to patients. They related the benefits to the patient's *experience* of seeking and receiving health care. Doctors placed patients' emotions at the centre of their talk about the benefits of personal care. In general terms, seeing a known doctor was thought to enable the patient to predict the doctor's response and, so, to aid the her to feel more comfortable and at ease about deciding to consult and once at the consultation. For instance, when I asked Dr. Kerry if she thought that getting personal care was important to patients, she replied:

Dr. Kerry: *'I would think it is. I mean, some patients hate going to the doctor and, presumably, it's because they don't know the person they're going to see... and if they know and feel they can talk to me, then, that must make it easier...'* (Dr. Kerry, MD 03-06).

Similarly, it was expressed as reducing the patient's fear and anxieties, exemplified by Dr. Neill here:

Dr. Neill: *'I think I have a warm façade... you know, it's just the way you greet them first of all... they feel that you are glad to see them... and, you know, good eye contact, and then just feeling that you remember, maybe a quick glance at the notes while they are coming through about their previous problems, so that they feel, "Gosh, he remembers me", and you say something about the family, "How's so-and-so? How's your mother?" These are the sort of things I think make them just help them feel at their ease... and just make them feel that bit at home... so that they are not frightened about coming (Dr. Neill, MD 04-02).*

Doctors also talked about personal care as enabling patients to bring to the doctor any problem they were concerned about, without worrying about the doctor's reaction:

Dr. Benton: *'... people feel that they can come in and say anything and... they won't get laughed at and they'll get help...'* (Dr. Benton, MD 01-02).

As did patients, doctors linked personal care to facilitating the patient to consult about any problem, thus, widening the parameters of what it was deemed legitimate to seek care about. In this regard, the patient's subjective experience of the problem was of paramount importance in determining what constitutes a legitimate matter for consultation.

Also in keeping with patients' accounts, it was described as helping the patient to talk freely during the consultation, to give details of symptoms and other

relevant information, to ask questions, and to 'open up' about any problem, including raising more difficult, painful or embarrassing issues:

RA: *'And some of those benefits, we kind of touched on those a bit earlier. What do you see those as being?'*

Dr. Lorimer: *'I think they're [the patients] more likely to confide in you, ask you things that have been maybe worrying them, that they're a bit, don't know if they really want to ask..., it's so much easier to talk to someone that you know well about things'* (Dr. Lorimer, MD 03-06).

Further, doctors also noted how personal care facilitates the disclosure of information during the consultation:

Dr. Strong: *'I think that they trust that you are going to take it seriously and that they are exposing things about themselves and perhaps being vulnerable either in terms of some sort of story or even or something to do with a part of their body that they may feel vulnerable about. So, I think it does make it easier for people to reveal things'* (Dr. Strong, MP 01-02).

The improved ability of patients to 'open up' was also expressed as facilitating the doctor herself to raise difficult issues with the patient. For instance, Dr. Johnson explained that knowing the patient helps him to discuss delicate matters, give bad news and reach negotiated agreement over action:

Dr. Johnson: *'I think when it comes to imparting information, then it [knowing the patient] makes a difference'.*

RA: *'In what way?'*

Dr. Johnson: *'I think if people, if you have to, if you have to break bad news, for example, or if you perhaps decide to take a line of management the patient wasn't expecting. I think it's probably much easier to reach agreement with the patient and his family if you know them well than if you don't know them at all'* (Dr. Johnson, MD 03-04).

As the extracts from Dr. Lorimer and Dr. Johnson above suggest, and as is evident in patients' accounts, personal care was thought to facilitate the patient in taking an active part in the consultation and in the overall process of their care. Indeed, doctors felt that they could be more readily attuned to, and meet, the patient's agenda, discuss difficult issues, and negotiate an agreed plan of action as a consequence of having a relationship or, as one doctor put it, to bring about *'a meeting between experts'* (Dr. Roberts, PD 01-01). Similarly, another doctor explained:

Dr. Ibsen: *'I mean I think the whole thing of trying to clarify the patient's agenda... is obviously vital... trying to involve them in some sort of mutually agreeable plan of action. I mean that is very central to the whole business that we're involved in. So, to get that, to achieve that satisfactorily, has to involve some personal interaction... I think it would be very hard to, perhaps there are some sort of fairly basic mechanical things that can be got through without that...'* (Dr. Ibsen, MD 03-03).

Indeed, connected to the idea that personal care supports patients emotionally, helps them to fully participate in the consultation and to *'open up'*, doctors claimed they were enabled to *'get behind the presenting problem'* to any deeper issues of concern that might be causing the patient's symptoms or be the *'real'* reason for the consultation.

In addition, like patients, doctors also talked about personal care as having the benefit of sharing a relatively high level of assumed knowledge that could be taken for granted and, thus, that reduced time-consuming repetition. This was expressed as beneficial for both parties. To exemplify this stated benefit for patients:

Dr. Clarke: *'... if that illness, as many of them are, particularly in elderly patients, is recurrent or an ongoing problem, then every time the patient comes in, it means they don't have to start from 1955 when it started'* (Dr. Clarke, MD 01-03).

To exemplify this stated benefit also for doctors:

Dr. Kerry: *'It's so much easier for both parties not having to repeat the whole history every time... it lets you get to the nub of the problem quicker'* (Dr. Kerry, MD 03-05).

Paralleling patients' accounts, a few doctors also talked about personal care as facilitating greater access to the doctor. The sense of responsibility for, and commitment to, the patient's well-being engendered in the doctor was said to result in them making efforts to be more 'available' to those patients. Dr. Lorimer gave an example of a known patient, who had difficulty getting a speedy appointment with her and whom she accommodated that morning by starting her surgery early:

Dr. Lorimer: *'...like someone I see couldn't get an appointment until next week, so she came in at half-past eight this morning...'* (Dr. Lorimer, MD 03-06).

Thus, there are many similarities between patients' and doctors' accounts of the benefits personal care brings in relation to the patient's *experience* of care.

However, doctors also talked about the importance and value of personal care in a way that includes their own experience of providing that care. It was distinctive as a feature of doctors' talk because it focused on of its importance and value to them specifically. As I noted in Chapter Five, personal care was constructed by doctors as the *raison d'être* of General Practice. It was frequently described as a 'pastoral' vocation, essentially being about the interpersonal connection with people, and the main reason why they chose this particular branch of medicine. For example, when explaining why she had chosen General Practice and what she likes about the job, Dr. Benton said:

Dr. Benton: *'... we were brought up to think, if you could do something useful for the community that was a worthwhile way to spend your life... I like knowing people, I like knowing the people who come to see me'* (Dr. Benton, MD 01-02).

The identity of General Practice as a profession being linked closely to the concept of personal care was strongly expressed by doctors and is further exemplified here by Dr. Ibsen:

RA: *'Is giving personal care important for you as a doctor?'*

Dr. Ibsen: *'Yes, I think, I think it has to be. I mean, if you're not, [General Practice] medicine's very much about the relationship with your patient and if you're, I think, if you're not getting satisfaction or pleasure or being interested in these relationships, then, it's going to be a pretty miserable job...'* (Dr. Ibsen, MD 03-03).

As with Dr. Ibsen, all the doctors in the study attributed personal care as being what gave them professional satisfaction. Similarly, Dr. Neill commented:

Dr. Neill: *'I think personal care is very important ... I mean, to me, that is what, why we are doing General Practice, em, was to give personal, one-to-one care and to follow through from birth to death almost... and so, for me, it's a lot of what General Practice is about... for me it's more satisfactory to deal with the whole person over a long period of time and try to help their little problems of body and mind...'* (Dr. Neill, MD 04-02).

As Dr. Neill stated above, providing personal care was articulated as making the doctor feel fulfilled in the practice of medicine. It is both a significant articulation of doctors' experience of patient care and a statement of a core value in General Practice. Indeed, doctors commented that it was seeing the patient's problem improve over time and 'through their problems' that gave them satisfaction:

Dr. Quick: *'... there is tremendous job satisfaction out of it... and it's something that we shouldn't undervalue, people get well again, and successfully guiding them through these difficult times in itself is rewarding...'* (Dr. Quick, MD 04-05).

However, as I illustrated in Chapter Five, doctors' accounts were tempered, in this respect, by talking about personal care as problematic, including it being what makes them feel stressed and at risk of 'burn-out'. Although this facet of doctors' accounts is negative in nature, it also indicates the extent to which the



*experience* of personal care-giving is a significant and recurrent feature in them.

## **Quality of Health Care in Terms of Medical Outcomes**

Patients recurrently linked the benefits of personal care to the *quality of health care* provided and, so, to *medical outcomes*. As the data presented in Chapters Four and Five demonstrate, patients can be seen as adopting a bio-psychosocial approach to medicine. Linking physical health to factors such as '*personality*', '*lifestyle*' and '*emotional stability*' (Mrs. Thomson, PP 02-01), justified the doctor, in many circumstances, to hold wider, contextual knowledge so they could receive appropriate and efficacious treatment. The doctor holding knowledge about the family context was attributed with enabling the doctor to understand the patient's concerns in a wider context, so a more appropriate response and course of medical action can be taken, as exemplified here by Mrs. Inch:

Mrs. Inch: *'My brother had died of a tumour, of cancer, he had a tumour in his brain, and I went to the doctors and I said, "I'm getting these terrible headaches... ". I said, "I think it's a brain tumour" and I can remember, I think it was Dr, Johnstone and he kind of said, "That's quite a sweeping diagnosis" and he was really, he was so nice, he was lovely, but he said "And why do you think you've got a brain tumour?" I said "I'm getting headaches, oh, doctor, I think I've got a brain tumour", and he was so reassuring. But, if it hadn't been him, right, and I had gone along and said, "I'm getting headaches" [unfinished sentence due to interruption]...'*

Mr. Inch: *'Goodness knows what they'd have written down in your notes then, eh?'*

Mrs. Inch: *'I don't know, [name of husband], but what I'm saying is, that information made it easier for him to say, "You're panicking and it's natural, you're panicking and the odds against you getting what your brother got are, you know, astronomical and I know it's easy for me to say, but you really shouldn't worry"'* (Mrs. Inch, MP 03-03).

Knowing and being known by the doctor in the ways described by Mrs. Thomson and Mrs. Inch were generally connected to the receipt of high quality health care. Illustrating the fact that patients commonly equated the doctor taking an interest in such information with being a good doctor, Mrs. Ewan noted, for instance:

Mrs. Ewan: *'... it's like, they don't really know their job, then, if they don't know you, because you're their sort of client, aren't you?'* (Mrs. Ewan, MP 02-01).

Indeed, in general terms, personal care was attributed with improving the actual standard of medical care provided, the patients' trust in the doctor and confidence in the treatment received. For instance, Mrs. Watson connected the doctor having contextual knowledge about her to her trust in his judgement and ability to diagnose and provide her with efficacious treatment, compared to a relatively unknown doctor:

Mrs. Watson: *'I think that's why, if, if I hadn't had a good relationship with them, I might not necessarily have been as reassured as I was, I might have come away thinking, "Mmmm, he's probably just fobbing me off", but I don't believe that they were, because I trusted what they said. ...especially when it's somebody that you know... they understand the*

*effects of what's things have on your body... and it's somebody that you trust...' (Mrs. Watson, PP02-04).*

More knowledge and trust, resulting in the patient's greater acceptance of the doctor's diagnosis, was also said to increase adherence to the doctor's treatment and advice. Indeed, greater patient compliance was a prominent benefit attributed by patients themselves to personal care. Mrs. Watson continued:

*Mrs. Watson: '... if you're not confident of their abilities or confident that they are listening to what you are saying, then, no matter what treatment they give you, you're not going to be totally believing it, and may not follow their advice fully, as a result of that' (Mrs. Watson, PP 02-04).*

In addition, patients attributed personal care with the greater possibility of receiving individualized treatment. As discussed previously, a central aspect of how patients constructed what personal care means to them is the patient being known and treated as an '*individual in her own right*' (Mrs. Ewan, MP 02-01). Treatment being tailored to suit the individual patient was also considered an important benefit of such care. Individualized treatment was equated with the receipt of high quality care. Mrs. Inch, for instance, compared being attended by a known and an unknown doctor, in this respect:

*Mrs. Inch: '... so, if you're talking to somebody, then I think the information they give to you is geared towards you as an individual because they know you and they know your family. If you are speaking to a stranger, then they have nothing to go on other than your voice and what you are saying, and whether or not it makes sense to them?' (Mrs. Inch, MP 03-01).*

Furthermore, personal care was related to quality of health care through allowing an improved level of monitoring and management of the patient's treatment and progress by both the doctor and the patient herself. For example, Ms. Forrest, who suffers enduring mental health problems, explained that regularly seeing the doctor who knows her is important in the maintenance of her mental health. She stated she is aware during stable periods that, when becoming ill, she loses insight into her condition and that being known by the doctor is beneficial to her in this situation:

Ms. Forrest: *'... the best thing is seeing somebody who knows you, is that when I'm ill, I don't always know I'm ill, so the doctor might be able to tell, but then if the doctor doesn't know me, they're not really going to know'* (Ms. Forrest, MP 02-02).

Facilitating the monitoring of treatment and progress were not only cited as beneficial for enduring health problems, but also through an episode of illness. Mr. George described recently having experienced such an episode of illness that was difficult to diagnose and treat. In the interview, he had already linked seeing his own two doctors consistently over this period to receiving high quality care. The discussion continued:

RA: *'And did that suit you? Were you quite happy with having that continuity [seeing the same two doctors over an episode of care]?''*

Mr. George: *'It did suit me. It was good, it meant that we weren't, kept going back from the previous week. It was how I'd been doing from that previous time back to the time I was visiting, how things were improving, if they were improving,*

*what other, what we could do to maybe try different medications and stuff, which was good. In the end, it did its job basically'.*

RA: *'And it got sorted out?'*

Mr. George: *'Oh aye, aye... but because I was able to see the two same doctors, they were able to compare..., "Well, if he's on this medication for this week or two", and then tried something else, because it didn't seem to be doing the job or there was adverse effects, as there was with some of the medication'.*

Upon further prompting, he favourably compared this care from known doctors to the longer length of time he envisaged it would take to arrive at a diagnosis and appropriate treatment, had he been attending a number of different, unknown doctors:

Mr. George: *'Em, whereas other doctors, if you're seeing a different one, "We'll take you off this, put you on this" and it's difficult for them like to get it together' (Mr. George, MP 02-03).*

Furthermore, the doctor knowing the patient as legitimate, competent and trustworthy, as discussed in Chapter Five, was commonly expressed as helping the patient to obtain the best medical treatment. Such accounts typically make comparisons between the response of a known and an unknown doctor. For example, Ms. Nicols related a time when, in the absence of her own doctor, she consulted someone unknown:

Ms. Nicols: *'... I've had one or two instances with GPs that... I've had, em, a raging uterine infection and they told me I've*

*got the flu, go to bed with Paracetamol. I knew fine, so then I had to wait for two days until Dr. O'Reilly [her own doctor] came back before I got anywhere and by then I had to go straight back into hospital... that was the difference between a good GP and one that wasn't listening to what I was saying. You know, I've just had major surgery, I've got all the flu symptoms, it's an infection bleeding profusely and all the rest of it, "Take Paracetamol and go to bed". I hung up in disbelief, I was furious' (Ms. Nicols, MP 04-02).*

### **Quality of Health Care in Terms of Medical Outcomes: Similarities and Differences between Patients' and Doctors' Accounts**

Like patients, doctors also described the importance and value of personal care as relating to *quality of medical care* in terms of improved health outcomes. They talked about how knowing the patient well enabled them to make a more accurate diagnosis and, so, to recommend more efficacious treatment. This was regularly connected to the doctor being able to interpret the patient's presentation and symptoms more accurately. Dr. Abraham, for instance, commented that knowing the patient's wider context generally improved the medical care he could offer:

Dr. Abraham: *'... it is easier to help patients [medically] if you know more about them'.*

RA: *'What would you say is the kind of thing it's important to know about?'*

Dr. Abraham: *'If there are illnesses in the family... if you are involved with extended families and you know what's going on in families, illness-wise or other things, you can talk to people about those things, as well... sometimes, a lot of it can bring it*

*[the presenting problem] to perspective...*' (Dr. Abraham, MD 01-01).

Similarly, in this example, Dr. Munro explained that knowing the patient over time, and having accumulated contextual knowledge, facilitated his understanding of the problem and meant he could respond more appropriately in medical terms:

RA: *'So, this chap who came along to see you about those problems you were describing, do you feel that was a situation where you were giving personal care, as you think of it?'*

Dr. Munro: *'I think I was giving him personal care in that I knew about his past history as a sort of low-level medical condition, I knew about his family history, I knew about his work history because his wife had been saying that he'd been working away from home and... it was all very difficult... because of that I was able to reassure him fairly clearly that the symptoms he was describing, which were pains in the middle of his chest and feeling sweaty and so forth, were to do with anxiety about his impending redundancy rather than those of a heart attack... I hope he was relatively reassured about that...'* (Dr. Munro, MD 04-01).

Like patients, doctors also talked about how personal care engendered patient trust in the doctor's treatment. Such confidence was attributed with encouraging the patient to accept the doctor's diagnosis and treatment and, thus, to improve patients' compliance with any prescribed treatment or more general advice:

Dr. Johnson: *'It comes back to this business of trust... if patients trust you, then they know that what you have to say is*

*worth listening to. Whereas, I think it's very difficult for some people sometimes to accept what a doctor may tell them if they don't know them, they don't know anything about them...'* (Dr. Johnson, MD 03-04).

In parallel with patients' accounts, doctors said that understanding the patient's symptoms or concerns could be understood within their specific circumstances and enabled the doctor to respond in an individualized way to that person. This point was often emphasized through doctors' comparison of the difference between attending their own patients and those who are not known, as in the previous example from Dr. Munro.

Knowing the patient was also attributed in doctors' accounts with their increased ability to trust the patient. This was described as supporting the doctor to more easily and accurately assess the problem and, thus, to provide the most appropriate treatment. In many cases, doctors again made this point by comparing seeing a known with an unknown patient:

*Dr. Quick: 'Well, the example again would be the mums. I mean... you know, "Wee Jamie's not well", you know, "He has a temperature", or whatever. If I knew it was [name of patient], I know she's a caring mum who's got two kids, lives down the street and she's got a nanny and, you know, she hasn't phoned up for a year... I would take this pretty seriously because she never phones up, she's a sensible mum, she wouldn't phone unless she was worried about it. Now, after hours you get half a dozen plus of these calls. You can make judgments, judgmental judgments on people, the way they speak, their address, we have to do that...'* (Dr. Quick, MD 04-05).



In other words, doctors spoke about how knowing the patient makes it easier to assess the extent to which they can trust the patient and that this has an influence on their response to that patient. It was said to allow the doctor to make a more informed assessment about the patient's presentation and decide on the most appropriate course of action.

In addition, not knowing the patient was generally thought by doctors to make for greater uncertainty and an increased level of 'risk-taking' on their part. In these cases, the emphasis of the consultation was concerned with a more basic level care; no more than keeping the patient 'safe'. Indeed, doctors favourably compared the quality of the treatment they give to known patients, with those who are unknown, in terms of the extent to which they are medicalized. By this, I mean the doctor's response to the known patient was said to involve fewer medical investigations, hospital admissions and prescribed medications. Reduced medicalization was regarded as inherently positive by all doctors and was a further important benefit to patients cited by doctors. Dr. Roberts, for instance, described the provision of care to an unknown patient as:

Dr. Roberts: *'... defensive medicine, you have to cover everything... it's dangerous and uncomfortable, really... where patients go to see somebody new and, then, quite often they get shunted off into all sorts of investigations or tests or treatments or things which I think, in retrospect... were inappropriate really... because of fear of missing something'* (Dr. Roberts, PP 01-01).

Likewise, Dr. Lorimer compared seeing her own patient and someone unknown during the out-of-hours service. She made clear that, in the case of an unknown

patient, with whom there may be further opportunity to discuss progress, being 'safe' means carrying out more medical tests:

*'... if they came in off the street, you would tend to be more concerned about symptoms that they have probably, and you would do more tests, and I'm sure that's true because of the out-of-hours thing, I'm sure there's a lot more intervention done. I mean, we get sheets back and you think, "Oh, we didn't need to do that" because, if somebody's seen them cold, never seen them before, they would be more concerned about things that we would say, "No, that's alright"... it's much harder to see patients in [out-of-hours service], you don't know the people at all... and not knowing the history and the fact that you're pressurized probably leads you to admit more people... their own GP wouldn't necessarily admit them. I'm sure we do admit more people through [out-of-hours service]... you can say to them [their own patients], "If you're worried", you can say, "Come back tomorrow". You can do more of the sort of, "Oh, we'll give it twenty-four hours and see where it leads..."'* (Dr. Lorimer, MD 03-06).

Indeed, as Dr. Lorimer evidences here, seeing the known patient was usually seen to offer a welcome level of relative certainty and less perceived risk, due both to having greater knowledge of the patient and the opportunity to monitor progress, rectify advice or amend treatment over time. Continuity with the patient over time was described as giving doctors the chance to compare the development of a condition or problem and was regarded as essential to good medical care, as further shown by Dr. Clarke:

*Dr. Clarke: '... they [patients] can say, "It's the same problem, it's the same symptoms", and you can compare and contrast with the last time you saw them rather than having to start from the top...'* (Dr. Clarke, MD 01-03).

The benefit of reducing the number of investigations a patient has to go through is noteworthy, not least because it does not appear in patients' accounts.

Another benefit ascribed by doctors to personal care, which does not appear in patients' accounts, is the advantage of being able to better control and manage 'problematic' patients. A significant feature of doctors' accounts is that patients who are difficult to engage, who are resistant to being known by the doctor, who might 'abuse' or 'be manipulative' of the system or individual doctors, can be dealt with more effectively if they are subject to personal care. Patients with addictions were noted as especially problematic, and as being in particular need of personal care in these accounts:

Dr. Kerry: *'... some of the drug addicts will do that [not stay with one doctor in the practice] because they know that, if they stick with Dr. A., he's going to be trying to reduce their Methadone next time, so, they'll go and see Dr. B. instead, and you can look through and see the people who, and I usually say, "Well, look, you really ought to be seeing the same doctor, make an appointment...". So, in that situation, I would encourage people to try and stick to the one doctor'* (Dr. Kerry, MD 03-05).

Similarly, Dr. Emmerson made reference to those problematic patients who most needed personal care in order that they could be better monitored. When I asked to whom he was referring, he replied:

Dr. Emmerson: *'... people who are on drugs of abuse and you get the opinion that they're just playing around to see who is the weakest [doctor in the practice]...'* (Dr. Emmerson, MD 02-02).

Examples of the benefit of personal care allowing the doctor to more effectively monitor and control problematic patients include dealing with drug abusing parents and in other situations where the doctor generally has a welfare role in relation to their patients' children. In this case, obtaining information from every possible source, such as allied practice staff (including reception staff) and patients' family members was said to be at a premium. In keeping with the findings presented in Chapters Four and Five, this was more prominent in practice areas with a high deprivation score.

The importance and value doctors placed on personal care are much in evidence. In concert with patients' accounts, doctors expressed these both as relating to the patient's *experience* of care and to the *quality of medical care* provided. However, it is not the case that patients placed equal significance on receiving this type of care in every situation; its level of importance was contingent on a range of circumstances, and it is to this I now turn.

## **The Importance and Value of Personal Care is Context-Dependent**

Notwithstanding the numerous benefits ascribed by patients and doctors to personal care, the importance placed on seeing a known doctor was not universally applied. Patients identified situations where it is of greatest value and others where it is traded-off against competing priorities or is deemed completely irrelevant. In short, the perceived need for personal care varied

according to a given situation. It was contingent upon patients' view of the particular circumstances at hand and, thus, to be context-dependent.

First, patients described personal care as being at a premium for problems which are characterized by ambiguity or complexity. This is evident in relation both to obtaining a diagnosis and to receiving efficacious treatment. For instance, Mr. Inch noted that seeing the known doctor had been most important to him at a time when he experienced worrying symptoms and an accurate diagnosis and efficacious treatment had been elusive. He had already stated he usually enjoyed good health and, normally, would not care which of the numerous doctors he consulted from a fairly large practice. However, this changed when he experienced severe leg pain and obtaining a diagnosis of the problem took several months:

Mr. Inch: *'... I started having problems... a sore knee which was pretty sore but certainly not life-threatening, and I started to go along to see one doctor... and, on that occasion, I used to ask for that doctor, but it was only through pure frustration at not being able to get a diagnosis of what was wrong... well, it was about five months I got diagnosed with this illness... but that was the only time...'*

RA: *'So, what do you think the benefit was for you, of sticking to the one doctor in that situation with the one ongoing problem?'*

Mr. Inch: *'Well continuity, obviously... it was a particularly serious time, but, em, I think the, as much as it was good to get the continuity, once it has sort of been diagnosed, because, it was, "Let's try this", you know, "Let's try something else", you know, so you sort of score things off the list, em, you would*

*be able to discuss the options and all that carry on, so it was good from that point of view'* (Mr. Inch, MP 03-01).

Generally, patients' accounts indicate that personal care has greatest importance when confronted by an ambiguous or complex health problem either for a one-off episode of illness or a chronic condition. In both cases, being seen through the problem by the same, known doctor was emphasized as being important.

Likewise, personal care was expressed as being of particular importance when the problem is not only ambiguous and complex, but also serious and even life-threatening. When speaking about her daughter's long-term, multiple physical health problems, Ms. Vickers related:

*Ms. Vickers: 'We actually see the woman doctor, Dr. Strong, just because I've really built up a relationship with her, and she now knows all [her daughter's] funny things, and because [her daughter] had a lot of symptoms that are not normally possible, I don't have to explain all these things. So, it cuts out, for somebody like with me with very complicated symptoms, it cuts out having to explain every time...' (Ms. Vickers, PP 01-03).*

Second, pregnancy was a time when most interviewees specified personal care as having most importance and value to them. Pregnancy was described as being 'personal' in itself. For instance, Ms. Grange commented:

*Ms. Grange: '... I always saw her. I didn't see anybody else at the surgery, em, and I think probably that pregnancy care is more personal anyway, that you do more or less get the same doctor because you do build up a relationship with them during that time' (Ms. Grange, MP 02-03).*

Indeed, constancy of health care personnel for the duration of the pregnancy was regularly emphasized by both male and female patients. Ms. Leishman commented:

Ms. Leishman: *'... I definitely feel that you want to see the same doctor every time, if you can, and mostly it will be your GP... yes, if it was for pregnancy, I would expect to see the same person unless it was a real emergency in between times and they couldn't come.... when I was pregnant with my other daughter, I do think that has heightened importance'* (Ms. Leishman, 03-04).

Likewise, Mr. O'Neill, father of three, commented:

Mr. O'Neill: *'I think there is an overlap, em, depending on the type of care that's been provided. For example, if it's emergency care then I think the personal element is perhaps not so important, but if it's, em, say prolonged care, such as over the period of a pregnancy, then I think it is quite helpful to maybe know your doctor, em, or for the doctor to know the patient, em'* (Mr. O'Neill, MP 04-03).

Thus, pregnancy was viewed as requiring the same continuity with a known and trusted health care professional as episodes of illness and chronic conditions were seen to require.

Third, personal care was expressed as being of greatest value when patients carry a caring role, either as parents with young children or adults with serious and debilitating health problems. For instance, Ms. Nicols commented that

personal care was important *'when you have children, in particular'* (Ms. Nicols, MP 04-02).

Similarly, Mrs. Inch explained why the family had remained with known doctors, despite having moved outside the practice's geographical boundary:

Mrs. Inch: *'... especially because, by that time, we were going to have our first child, so it was important that you knew the people and trusted the people...'* (Mrs. Inch, MP 03-01).

In relation to caring for an adult, Mrs. Ewan explained that she had registered her husband, who was brain-damaged and used a wheelchair user, with her own doctor as this supported her in caring for him. Similarly, Mr. Uphall noted that personal care was of particular importance in helping him and his wife to care for his elderly and bed-ridden mother. Further, in the following extract, Mrs. Richardson underlined the point that personal care was of importance in supporting her to carry the heavy demands of her everyday life. She worked full-time, her husband suffered from permanent disability that prevented him from working, and her two daughters had chronic asthma. In discussion about her own doctor, she explained:

Mrs. Richardson: *'Eh, the doctor knows the two of them inside out... she knows it's going to be either 'A' or 'B' between asthma and periods... you're only in about five minutes because you don't have to go through the whole history of them'.*

RA: *'And you think that's an advantage?'*



Mrs. Richardson: *'Oh, I think that is a major advantage. Because when I work full-time, I don't have time to sit for half-an-hour in a doctor's surgery. If you just go in, get seen, get what you want and out the door...'*

RA: *'So, you think that personal care is maybe more important to you because of the children?'*

Mrs. Richardson: *'Yes. I think it is just the family unit and you want the family unit to be stable... he's got problems [her husband], the two kids have got problems... I just like the family unit to be stable and whoever goes down to the doctor is going to come out with the right answer'.*

RA: *'So, it kind of relieves pressure from you, knowing that you've got a medical service there that you can rely on?'*

Mrs. Richardson: *'Oh, definitely, yes, I mean... since 1993 I've been the main breadwinner... I couldn't do that, go out to work confidently thirty-nine hours per week... so, I wouldn't have the confidence to go to work them thirty-nine hours per week if I knew that was going to fall apart... because a family unit has to be so secure' (Mrs. Richardson, PP 02-03).*

Fourth, patients gave priority to personal care when dealing with problems that are of an intimate, more personal nature. As discussed earlier, such care was imputed with the benefit of supporting the patient to consult about these types of matters, to disclose more information and to enter into the consultation more fully. Thus, personal care was deemed to be most important for many other situations that involved discussion of intimate or embarrassing problems:

RA: *'Are there things that you would talk to your doctor about, say Dr. Emmerson [her own doctor], that you wouldn't speak to anybody else about?'*

Mrs. Ewan: *'Em, yes. I mean I think if it was to do with a lump in my breast, or something like that, I think I would prefer to go and see either Dr. Emmerson or Dr. Davidson because that's the two I'm really close with, you know. Things like that, if I found a lump on my breast or if I felt I was having a miscarriage or something like that, yes, I would definitely go to Dr. Emmerson about those things, more in-depth. But, if it was just a case like, well, I've got back pain or something, then, I would go to any doctor, you know. If it was something more personal to do with myself or to do with depression, or something like that, then I would prefer to see my own doctor'* (Mrs. Ewan, MP 02-01).

Indeed, life threatening illnesses, such as cancer, psycho-social problems and some of those deemed intimate were regularly noted as situations where personal care held the greatest salience for patients.

However, as we saw in Chapter Five, accounts of seeing the known doctor for more intimate problems also indicated that for some complaints, such as gynaecological matters, gender featured as a consideration in the importance patients placed on personal care. Most women in this study, who emphasized the value of this type of care, privileged seeing a female doctor over their own male doctor for gynaecological problems or internal exams, even if this meant seeing an unknown doctor each time:

Ms. Nicols: *'... Well, I go to the Well Woman Clinic so things that are more personal in ways of a gynaecological, I would probably go to the Well Woman Clinic for, only because there is not a female GP in the practice'* (Ms. Nicols, MP 04-02).

Thus, gender difference factored in female patients' decision-making about which doctor to consult when facing some personal or intimate problems and where a problem could be considered too personal to discuss with the known doctor, when related to the issue of gender.

As demonstrated by Mr. O'Neill, Mrs. Ewan and Ms. Leishman above, patients commonly discriminated between problems that were ambiguous, complex, serious, and some that were intimate in nature, and those perceived to be emergencies or more 'everyday' complaints when considering how important personal care is. Indeed, patients regularly talked about trading-off seeing the known doctor in order to get speed of access to any health care practitioner for emergency or acute care:

RA: *'Do you tend to see the same doctor when you go there?'*

Mrs. Thomson: *'Usually, but then if it's a sort of urgent appointment or something, I would see any of the doctors at the practice'* (Mrs. Thomson, PP 01-01).

An example of such a trade-off also being made when faced with an ailment considered to be everyday is provided by Ms. Leishman:

RA: *'You were saying that, em, there were some things that seeing the same doctor for was less important for, I think, like going about a verruca. Could you say a wee bit more about that...?'*

Ms. Leishman: *'Well, an example is where you think it's just a viral infection and temperature and being sick, it would be more important to see any doctor that day because I wouldn't*

*wait for a particular doctor and things like, yes, can you confirm this is chickenpox? ... I don't think it would matter which doctor'*

She went on to specify those situations where, conversely, personal care was of primary importance to her:

*Ms. Leishman: 'Em, I'm trying to think, the ones where I, well, gynaecological and psychological things that I go to the doctor about, I choose to see the same female doctor because I feel more comfortable...' (Ms. Leishman, MP 03-04).*

Similarly, Ms. Vickers, who had emphasized above the importance of seeing her own doctor when dealing with her child's complex health problems, provided a typical example of patients' accounts of discriminating when personal care has most value:

*RA: 'So, you would make that kind of judgement, then, about whether you wanted to wait to get her, or whether you just saw whoever?'*

*Ms. Vickers: 'Well, I suppose it depends on whether it's something that's an acute thing, where you really are feeling terrible and you need, I mean, I can probably tell myself when I need an antibiotic for my throat, but I can't write the prescription, so it doesn't really matter who it is, or they'll say to you, "Well, yes, you've got a terrible sore throat and you've got a virus, or you've got a bacterial thing" ... I suppose, if it's my throat, I don't care who it is, but there are personal things that you want somebody that you know' (Ms. Vickers, PP 01-03).*

These data illustrate how patients commonly attributed a level of importance and value to personal care, according to their view of the nature of the presenting problem at any given time, rather than the overall status of the patient's health. Thus, its importance and value are found to be fluid and context-dependent and not static and related to one aspect or characteristic of any individual patient.

### **The Importance and Value of Personal Care: The Similarities and Differences between Patients' and Doctors' Accounts**

Like patients, doctors also considered personal care to be more important for patients with ambiguous, complex and long-term problems. For instance, without prompting, Dr. Strong noted personal care has greatest significance for certain groups of patients:

Dr. Strong: *'I think that sometimes where this matters most is obviously the people with complex or chronic problems, long-term problems, really...'* (Dr. Strong, PD 01-02).

These complex and chronic problems include the patient having a physical condition, such as diabetes, diverticulitis or, as in the following case, ischaemic heart disease:

RA: *'So, would this be a good time for you to tell me about the couple of cases that you think you give personal care to?'*

Dr. Ibsen: *'Yes, for chronic diseases, so a lot of them are elderly, or late-middle aged, at least. Somebody with, em, with ischaemic heart disease, we've been through a lot of problems*

*with that, you know, and I suppose the people like that that come to mind...*' (Dr. Ibsen, MD 03-03).

It was also thought to be important for those patients suffering from enduring mental health problems, such as depression. Dr. Clarke (MD 01-03), for instance, talked about how it was important to have personal care with those suffering from depression because they lack '*insight*' and tend to '*resist*' medical intervention. She stated this increased the importance of the patient having a good relationship with the doctor, if diagnosis and treatment were to be properly effected.

In addition, personal care was expressed as being of particular importance for patients with problems where care is required both for the individual concerned and for the family, such as people with special needs or suffering from terminal illness:

Dr. Abraham: *'I think if you can access all the family who have got significant problems like handicapped children, cerebral palsy, these kinds of things. I think they need more personal care because they need to know that is something goes wrong, however slightly, they can talk to you about it... So, I think others are... families where there is a lot of ill-health or a lot of problems, personal, I mean, insoluble problems, and obviously at the end of the day even terminal care, personal care is better...'* (Dr. Abraham, MD 01-01).

Thus, as Dr. Abraham stated, it was also considered to be of most importance to those patients with considerable psycho-social problems, and those whose

difficulties were enduring, complex or 'insoluble'. Dr. Emmerson made the same point:

Dr. Emmerson: *'Em, but, mainly, it's just if someone has been managed for illnesses that might have a psychological component, mental depression or any of the chronic conditions... usually things that require the art of medicine as well as the science. You know, someone comes along and they've got tonsillitis, and... it's just like having a car serviced, if you like, it doesn't matter who changes the clutch. But, if you have to make a diagnosis or management which involves more complex, psycho-social element things, I think it should be the same person...'* (Dr. Emmerson, MD 02-02).

Personal care was regularly cited as being necessary to ensure that such problems could be most effectively dealt with, both in terms of the quality of the medical care provided and the patients' and doctors' experience of the interaction. Indeed, Dr. Lorimer also noted this explicitly in relation to patients with complex and chronic conditions and, in particular, she referred to women attending for ante-natal care:

Dr. Lorimer: *'For people with chronic problems it's really important. It's nice if they do stick to seeing one person because it's difficult to come in cold and to a big, long, complicated problem and make any sense of it and do the appropriate things. Em, I suppose the elderly, just partly because they tend to have more things going on, em, people who have lots of appointments about the same thing, you know, for ante-natal patients, for instance. It's nice if they stick to one person because it's also nice to build up a relationship with these people because they're more likely to discuss things with you and because you'll see a lot of them, I guess'* (Dr. Lorimer, MD 03-06).

However, Dr. Lorimer was unusual in pinpointing pregnancy as a time when personal care has high salience for patients. It was not a strong feature in other doctors' accounts, relative to those of patients.

As indicated by Dr. Emmerson above, doctors often described the type of patients for whom personal care has most importance by comparing them with those with conditions where it was thought not to be so relevant. Again, in this respect, doctors' accounts resonate with patients. They noted that personal care had no particular salience for certain complaints, typically expressed as problems that were 'minor'; common, everyday illnesses that were 'self-limiting'. For example, Dr. Munro stated:

Dr. Munro: *'I suppose there's probably a group of patients for whom not having personal care is completely OK, as it were. ... people, who come in for episodic things... "You've got a sore throat. Yes, it will take time to get better. No, there isn't much I can do about it", the sort of easy reaction to the symptom, prescription and kind of out of the consultation...'* (Dr. Munro, MD 04-01).

Similarly, Dr. Strong commented in this respect:

Dr. Strong: *'For example, urinary tract infections, coughs, colds, chest infections, I probably see as many of other people's patients as they see of mine...'* (Dr. Strong, PD 01-02).

However, one caveat that emerged from doctors' accounts is that many of them simultaneously regarded seeing patients for minor complaints as being



important for building the relationship with the patient over time. I discussed this earlier in relation to the doctor 'investing' in the development of the patient-doctor relationship:

Dr. Neill: *'I feel that I give my patients personal care... it's a one-to-one thing and whatever the kind of problems they may have, they come to me and I try to help them... so, that say anything they have wrong from the most mundane things to really quite devastating things, you know, you are forming the bond... and, you know, there is a rapport there...'* (Dr. Neill, MD 04-02).

Thus, whilst some doctors considered that personal care had greatest importance for patients with specific types of conditions or in particular circumstances, mainly they viewed treating the patient for minor complaints as having a value in itself in terms of building the relationship with the patient.

Overall, doctors' accounts paralleled those of patients in discussion of the contingent nature of the importance and value of personal care. Doctors recurrently stated that it was of greater importance to particular groups of patients, as well as when patients were in certain specific circumstances. However, there was a difference in the emphasis placed on the explanation for this contingency. Doctors tended to talk about its importance in terms of patient groupings rather than patients' immediate circumstances. Also, the description of its importance in terms of it being a valuable investment was absent from patients' accounts, and constitutes a further distinctive feature between the two.

Moreover, a significant recurrent theme in doctors' accounts, not present in patients', is that personal care has importance when caring for patients deemed problematic. I explained earlier that doctors claimed there was great benefit in giving personal care to patients who had complex and long-term problems and were difficult to engage or resistant to being known by the doctor and who might 'abuse' or be 'manipulative' of the system or individual doctor. This benefit was explained as allowing the doctor, and indeed the practice as a whole, to more effectively monitor and manage such patients. The corollary to this is that problematic patients were specified as a group for whom personal care was especially important. Typically, these were patients abusing drugs, as exemplified earlier by Dr. Benton and Dr. Emmerson.

Likewise, such care was deemed to be essential for patients who 'somatized' and were 'neurotic' (Dr. Davidson, MD 02-01), and those where issues of child protection pertained. In this example, Dr. Emmerson talked about a patient for whom personal care was very important because she feigned symptoms of illness that may not be spotted by an unknown doctor:

Dr. Emmerson: *'I mean, there's a lady I know who could very successfully mimic an acute abdomen and a heart attack, her two party pieces, if you want to put it that way... now, if regular members of the practice were seeing her, they'd gradually learn over a period of time to distinguish between when she was putting it on and when she wasn't, by various little tricks and gimmicks, whereas a new doctor didn't and would rush her into hospital and she's be treated inappropriately...'* (Dr. Emmerson, MD 02-02).

## **The Value and Importance of Personal Care, Practice Size and Deprivation Score**

In Chapter Four, I discussed how patients from small practices often constructed personal care as knowing and being known by all of the two or three doctors in the practice. In large practices, however, they tended to talk about this in relation to one particular doctor whom they identified as their own from the six or more practice partners. No differences in patients' or doctors' accounts of the importance and value of personal care appear in relation to practice size. However, in keeping with the variation in meaning construction, one notable exception is that patients' trading-off activity was greater in the large practices than in the small. Gaining access to the known doctor was said to be more problematic, presumably for the logistic reason that surgeries are shared between more doctors. In smaller practices, fewer doctors share the surgeries, facilitating patient access to the preferred doctor, whilst patients are more likely to get to know all the doctors fairly well as a result of the trading-off activity that does occur.

In terms of deprivation score, the only difference identified in respect of this second research question is the greater emphasis placed by doctors from more deprived practice areas on the benefit of personal care in controlling and managing the, so-called, problematic patient that was relatively less prominent within more affluent practice areas.

## Summary and Discussion

In this chapter, I have tackled the second research aim and presented data on the importance and value interviewees attributed to personal care, and the context of this. These data, therefore, arose largely from pre-set research questions. Once again, they lend support to many of the dominant themes discussed in Chapters Four and Five, including that, when interviewees talked about personal care they adopted a bio-psychosocial approach to medicine. Also, paralleling Chapters Four and Five, the similarities between patients' and doctors' accounts in respect of this second research question are striking.

A number of benefits were attributed by interviewees to personal care. These included; helping patients in the act of care-seeking, aiding speed of access to care, and ameliorating the negative emotion that can attend illness and health-care. It was also said to foster *mutual trust*, facilitate the patient to 'open-up', participate in the consultation more fully and negotiate the desired outcome more easily. It was generally attributed with improving medical care, individualizing that care, reducing unnecessary medicalization and increasing patient compliance. For patients, it was credited with supporting them in their everyday lives, especially in a caring role when looking after children or 'dependent' adults. The importance and value of personal care was often expressed as lying in the everyday demands of people's lives and familial/social circumstances. For doctors, it was said to enable them to be beneficent in their care of patients and also to control and manage those patients deemed problematic. It was also described as providing occupational satisfaction, but to place demands on their personal resources.

Indeed, a primary finding evidenced in this chapter is that, in the context of an evolving NHS, which is placing considerable emphasis on speed of access to the first available practitioner (Scotland, NHS plan, Scottish Executive, 2001) and the first available GP (England, NHS plan, Department of Health, 2000) within twenty-four hours; on population level medicine; and on the diffusion of care tasks across multi-disciplinary teams, personal care from one or a small number of known health care professionals has continuing salience to patients and doctors alike. Interviewees ascribed many significant benefits to such care, which were related to the themes of the *experience* of seeking and receiving health care and to the quality care provided in terms of *medical outcomes*.

Personal care, characterized by *mutual knowing* and *mutual trust*, was articulated as an important factor in making the decision to seek care by widening the parameters of what they would take to the doctor. It was said to encourage and facilitate patients to seek care about issues deemed too 'trivial' or some that were experienced as too intimate or embarrassing to consult an unknown practitioner about. These findings contribute to the now well-established body of work on lay understandings of health and illness and health-seeking behaviour. Work on the concept of 'illness behaviour' (Mechanic, 1961; Zola, 1973) considers how people interpret symptoms of illness and take action about those symptoms in terms of deciding whether to seek health care. Meaning-making and illness behaviour are found to be socially patterned with variations existing between people in terms of social class, religious denomination and the extent to which symptoms and illnesses are common amongst the cultural

group to which the person belongs and the perceived level of danger associated with them in that group. Social and cultural contexts have become accepted as important loci in which the person understands and reacts to symptoms of illness. Mechanic explains the importance of taking account of this wider context in understanding lay use of health services:

*'... a precise understanding of medical aetiology... if health programs are to operate at maximum effectiveness, it is essential that we have a deeper understanding of the concept of illness behaviour. It is necessary that we learn a good deal more about the various attitudes, values and social definitions applied to symptoms, and how these influence the adoption of patient roles' (Mechanic, 1961: 194).*

Other work that has examined how people make sense of health and illness and related behaviour, such as deciding when to seek care, has provided solid empirical evidence of it being inherently bound with their everyday cultural and social experiences (Blaxter and Paterson, 1982; Cornwell, 1984; Backett, 1989; Backett and Davison, 1995). The data presented in this chapter suggests that one factor influencing patients' health-seeking behaviour is their experience and knowledge of the doctor, their perception of the way in which they are known and how the doctor is likely to respond when presenting with a problem.

Many of these self-reported benefits identified in this study concur with Preston *et al.*'s (2002) qualitative study of patients and health care professionals on personal care in General Practice. They found that interviewees reported personal care as advantageous to patients in terms of: improved

communication; patient compliance; giving patients higher expectations that medical outcomes would be better; care being more effective; and care being individualized to the particular patient. For health care staff, greater occupational satisfaction was also reported as a result of giving personal care. In short, in keeping with this thesis, these researchers found that a range of benefits were attributed by both patients and health care professionals to personal care, which are related to improvements in both the *experience* of care and the quality of care in terms of *medical outcomes*.

Further, the data of this thesis provide evidence to support the findings of some quantitative studies, which indicate a positive association between care with a personal component and improved outcomes or patient satisfaction. For instance, these findings concur with several such studies (Becker *et al.*, 1974; Ettlinger and Freeman, 1981; Kaplan *et al.*, 1989; Gulbrandsen, 1997; Howie *et al.*, 1999; Love *et al.*, 2000), in the following respects. Personal care was said to impact favourably on the patient's behaviour once at the consultation; it facilitated the patient to fully participate in the encounter and in the overall process of care; it enabled the patient to reveal and discuss intimate problems and to express emotion; it fostered patient trust in the doctor; and it aided the doctor to gauge the patient's emotions and get behind the 'presenting problem'. Further, these data suggest personal care allows the doctor to adopt a more 'expectant management' approach, as was found by Hjortdahl and Borchgrevink (1991) in a Norwegian study of primary care.



Indeed, in this thesis, doctors reported the level of uncertainty they could live with, and concomitant risk they were prepared to take, was greater with known patients. Doctors described this as resulting in a reduction in patient medicalization, including less emergency admissions to hospital, referrals for invasive medical tests and use of prescription medicines. Again, these findings are consistent with other studies that have found a positive association between continuity of carer and lower rates of hospitalization (Wasson *et al.*, 1984; Gill and Mainous, 1998), less use of emergency departments (Christakis *et al.*, 1999) and fewer prescription medicines (Hjortdahl and Borchgrevink, 1991).

Access to a health care professional was also said to be facilitated by personal care. Contrary to some debates about health care policy noted in Chapter One (McCormick, 1996; Taylor, 1997), speed of access and personal care were not talked about as discrete or oppositional concepts. Knowing and being known were thought to help patients gain quick access when deemed necessary. It also facilitated doctors and allied practice staff to gauge more readily the 'legitimacy' of the patient's demand.

Once again, as evidenced in Chapters Four and Five, the data presented in this current chapter reveal that patients did not focus solely on medical outcomes when discussing the importance of personal care. The experience of the care provided was also significant in its reported benefits. Similarly, the emphasis placed on the patient being known as an individual person whose interiority (Armstrong, 1983 and 1985; May *et al.*, 1996) and wider life context are legitimate and necessary spheres of knowledge for the provision of good quality



care is prominent in interviewees' discussion of importance and value. In particular, it is noted that patients were enabled to be more open with the known doctor and disclose intimate and personal information, and the doctor could use her skills more readily to facilitate such disclosure and get behind the presenting problem.

However, the data presented in this chapter also demonstrate that the importance placed on seeing a known doctor is not universally applied. Patients identified situations where it was of greatest value, others where it was traded-off against competing priorities and some where it was deemed completely irrelevant. The perceived need for, and value of, personal care varied according to the nature of the health problem and circumstances at hand. In short, it was context-dependent. Personal care was said to be of most importance in situations where the problem is ambiguous, complex, serious, and, in some cases, intimate. Patients discriminated between the sorts of problems that had high emotional salience and situations perceived to be emergency or acute, as well as more everyday complaints. These data provide evidence that patients' health status is not the only indicator of the importance of personal care, but that attendant circumstances also play a significant role in this.

Again, doctors' accounts are noteworthy for their similarities with patients'. Both discussed the benefits of personal care in relation to the *experience* of health care and the quality of care in terms of *medical outcomes*. Most particularly, both sets of accounts revealed the beneficence of personal care. However, doctors'

accounts differed in four main ways. First, patients tended to talk about the contingent and context-dependent nature of their own particular circumstances in relation to the importance and value of personal care, whilst doctors talked about it more in terms of patient groupings and as being important for all consultations as a form of banking for the future. Second, doctors spoke about how personal care enabled them to undertake more expectant management with patients, live with greater uncertainty and higher levels of risk, and reduce patient medicalization that was not present in patients' accounts. Third, it was said to facilitate the doctor to identify and more rigorously control and manage those patients deemed problematic, also not discussed by patients. Fourth, as is present in Chapter Five, doctors discussed its impact on their own experience of providing such care, simultaneously as what gives them occupational satisfaction and what places excessive demands on their personal resources.

No differences are noted in interviewees' accounts of the importance and value of personal care in respect of practice size. However, the comparatively greater problem of access to the known doctor, and resultant trading-off activity undertaken by patients from large practices, is noted. The only difference identified in terms of deprivation score is that doctors in more deprived areas talked relatively more about personal care as a means of identifying and managing the problematic patient.

# CHAPTER SEVEN

## Discussion and Conclusions

*'... hegemonic medical discourses and medical practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximize their health status and avoid physical distress and pain' (Lupton, 1997 b: 94).*

### Introduction

In this thesis, I have tackled the two research aims set out in the introductory chapter; first, *how do patients and doctors construct the meaning of personal care in General Practice*, and, second, *what importance and value, if any, does it hold for them, and in what contexts?* Meeting these aims has been dealt with in the preceding three findings chapters.

In dealing with the first research aim, I have shown that interviewees talked about personal care in three distinctive but overlapping ways: as *personal consultation style*; as *whole practice care*; and as *relational continuity*. Further analysis within each interview reveals that interviewees talked simultaneously about these categories of meaning, and a relationship can be imputed between them. Personal care was mainly conceived as care given in the context of a relationship with one or a small number of doctors built over time, characterized by *mutual knowing* and *mutual trust* and in which the doctor adopts a particular consultation style. *Mutual knowing* and *mutual trust* involve

the experience of an interpersonal connection between patient and doctor. In constructing the meaning of personal care in this study, interviewees' accounts drew upon and were embedded in the wider discourse of bio-psychosocial medicine.

In dealing with the second research aim, I have shown that interviewees placed significant importance and value on personal care, and ascribed numerous specific benefits to it. In particular, personal care was deemed to have the benefit of enabling patients to be known as legitimate and trustworthy and, so, to obtain the health care they consider necessary. For doctors, it was especially noted as permitting them to extend the beneficence of care to patients and to identify, control and better manage the, so-called, problematic patient. However, the level of importance and value it was said to hold for patients varied; it was contingent upon their view of the health problem and the particular circumstances at hand. For doctors, problem-contingency was less prominent, and they talked mainly about personal care in all consultations as a way of banking or investing for the future in the relationship with the patient. It was also deemed by patients and doctors to be disadvantageous and problematic in some respects. Whilst interviewees largely embraced the concept of personal care, and *mutual knowing* as a key aspect of this, they also placed boundaries around it, regarded it, at times, as irrelevant and, sometimes, simply avoided it.

In this final chapter, I relate these empirical findings to existing social theory in order to develop a clear conceptual understanding of them, and to apply this

empirically-driven thinking to the policy and practice context of current primary care.

There are numerous important and interesting themes to emerge from this study that could be developed conceptually in this chapter. Given recent policy strategies and ensuing academic and professional debates about the continuing potential for personal care, I have chosen to focus on exploring two main themes; one that is sociologically-oriented and one that focuses on the policy implications of the findings. These themes have been chosen because of their prominence in the data presented across all three findings chapters.

The first theme I consider is how these data, which demonstrate patients adopted a bio-psychosocial approach to General Practice medicine and ascribed numerous benefits to it, whilst simultaneously placing conditions and boundaries around it, may be understood in light of previous work on the patient-doctor relationship in General Practice. This includes exploration of the emphasis on patient identity that has suffused these data. As a theme, patient identity was evident in the way interviewees presented themselves in a *particular way* to me during the research interviews. It was also a central feature of their accounts of the meaning and importance of personal care. Indeed, the key academic puzzle to emerge from these data is the question of patient agency, and it is this that I mainly address in the first section of this final chapter. In short, I consider whether patient agency was at work in the ways patients talked about the concept of personal care and witnessed in how they worked at presenting their moral identity to me as an interviewer? Or are these

data simply evidence of patients being duped through a state of 'false consciousness' into adopting a dominant medical discourse on doctors' terms that serves to control them?

I explore these data with reference to the main sociological perspectives that I have already outlined in the literature review chapter. I start with the modernist approaches of structuralism and interactionism, followed by consideration of the early post-structuralist work of Foucault and consider the key issues these perspectives raise about interpretation of these complex study data. I then consider the later work of Foucault (1986; 1988; and as discussed in Moss *et al.*, 1998), as I propose that this attends well to these issues and offers a more adequate understanding of the data. In coming to an overall understanding, I also draw heavily on the empirical work of Lupton (1996, 1997), who has produced similar findings to my own and has used Foucault's later thinking to interpret them, and on the theoretical work of Fox (1993; 1995), who examines the dual nature of the caring relationship within a post-modern context.

Then, as this thesis was motivated in part by policy changes within the NHS that were thought to be undermining the potential for personal care, the second theme I discuss is related to implications of these findings for the recent policy changes outlined in Chapter One. These data demonstrate that the concept of personal care resonates with patients, at the very least with women with young children, and has continuing salience for them in certain contexts. The proposed new GP contract, in particular, may impact negatively on the potential for such

care being provided in the future. I discuss the implications of the contract in the light of this study's findings.

## **Summary of Patient Data**

I wish to start by recapping the main conceptual points to emerge from analysis of patient data presented through Chapters Four, Five and Six, in order that they may be more clearly linked to the theoretical discussion that follows.

Overall, the study data show that, when discussing the concept of the personal, patients, not just doctors, clearly identified with and adopted a bio-psychosocial discourse of General Practice medicine. Personal care was attributed significant importance and value, and the numerous specific benefits it offered them were outlined. Throughout these accounts, personal care was equated with high quality primary care. It is noteworthy that patients talked in a mainly positive manner about such care, given the significantly negative theorizing of medical sociology about medicine, including bio-psychosocial medicine, as previously discussed in the literature review chapter. It is equally noteworthy that they did not talk about it in an exclusively positive way. These data suggest that patients were sophisticated and discriminating in understanding and engaging with the concept of personal care, of knowing and being known by the doctor. They actively embraced it whilst, simultaneously, treated it as problematic and placed boundaries around it.

More specifically, in Chapter Four, I showed that when patients talked about what personal care means to them, their accounts were embedded in, and drew

upon, the wider discourse of bio-psychosocial medicine. In these accounts, they emphasized the importance of their 'personhood', their individuality as people that must be taken account of if good quality care is to be provided. Indeed, for care to be deemed personal (and so good), the response and treatment of the GP should not be standardized, but tailored to suit the patient's idiosyncratic biography and personality, and targeted to meet her specific needs. The patient as sentient being, whose subjectivity and point of view are at the heart of the medical encounter, is clearly invoked in these accounts.

These data show that patients not only desired such care, but had an expectation that it should be on offer. It was deemed to be the doctor's professional duty. This expectation was usually particularized to care provided by the patient's own surgery, and rarely was related to hospital medicine or the out-of-hours service. General Practice, then, was regarded as the main context for the provision of bio-psychosocial medicine. Invoked, too, in this service provision context is the concept of the patient-doctor relationship. Patients regarded this relationship as key to the provision of good medical care and as a site in which the patient's individuality could be known, the doctor could be known and trust in the doctor could be forged. *Mutual knowing* and *mutual trust* were described as key characteristics of good personal care.

The emphasis in patients' accounts on knowing and being known by the doctor and on trust between patient and doctor was developed in Chapter Five. Patients recurrently subscribed to the clinical efficacy of the doctor holding personal and intimate knowledge about them. They were accepting, and even



expectant, that, in many situations, the doctor should hold details about their interiority, their wider family circumstances and their social context. These were all described as rightful spheres of GPs' knowledge in certain circumstances. This was mainly expressed, both explicitly and implicitly, in terms of the concept of whole person or holism that suffuses the data of both sets of interviewees.

Further, the interpersonal connection between patient and doctor was emphasized as being important to patients' positive experience of care. Patients did not just want to be known in a factual sense but, in certain circumstances, to share an interpersonal connection with the doctor at a more human, emotional or what may be thought of as an 'existential' level. These accounts highlight the focus that rests on the phenomenology, that is, the lived experience of the body, of ill-health and in seeking and receiving health care. They also demonstrate that patients want and need to have faith in the doctor and trust in her medical skill, and are willing to engage in the relationship to achieve these ends. Trust was mainly conceptualized as experiential; as that developed through experience and knowledge of a particular doctor over time, and constitutes both a characteristic and a benefit of personal care.

Chapter Six consolidates the evidence of the largely positive way patients talked about personal care, with knowing and being known constituting a key component of this. These data show that patients placed high value on such care and attributed numerous specific and wide-ranging benefits to it. Knowing and being known by the doctor were considered to be advantageous to their

experience of health care seeking and when actually receiving care. *Mutual knowing* and *mutual trust* facilitated the patient in the process of deciding to consult and supported their active participation in the consultation once there. It was said often to allow the patient to be more open with the doctor, to talk freely, to express her innermost emotions and to raise difficult, painful, embarrassing and intimate issues, often about her private life. The ability of the patient to be open with the doctor about these issues was deemed beneficial both for its therapeutic effect and as resulting in more efficacious medical treatment.

Generally, personal care was ascribed with ameliorating the effects of the heightened emotion that attends the experience of ill-health and of care seeking. It was described as providing a greater degree of certainty, comfort and security when faced with highly-charged, emotional situations. It was, therefore, found to be particularly valuable when dealing with problems that are ambiguous, complex, serious, life threatening and some which are intimate in nature. More particularly, it was attributed with supporting people in their social roles, especially when they have the responsibility of care for young children and 'dependent' adults. Indeed, the importance and value of personal care was often expressed as lying in the everyday demands of people's lives and familial/social responsibilities. The evidence for patients' eagerness to adopt personal care, embedded in the wider discourse and practice of bio-psychosocial medicine in General Practice, is abundant in these data. Far from regarding it as oppressive, harmful or constraining, patients usually desired and often expected such care from the GP, and it was experienced as being of great value.

As stated earlier, however, the significance of these study data also lies in their illustration that interviewees did not view personal care in an entirely positive way. Patients did not comprehensively or unthinkingly endorse it as an intrinsically beneficent force that cures all ills. Indeed, the data reveal that patients were sophisticated and discriminating in their accounts of personal care. Patients' accounts show they engaged with the concept of personal care in an active and complex way; these data are mainly contained in Chapters Five and Six.

The data presented in Chapter Five, show that knowing and being known by the doctor were essential, component parts of the construction of personal care to which numerous, significant benefits were ascribed. These included enabling the patient to be known in a *particular way*; as a legitimate patient with a deserving claim to service and as a competent and trustworthy person and parent. Patients, in effect, were engaging with the discourse of morality that suffuses medicine and constructing themselves accordingly. However, patients were also shown there to circumscribe and place boundaries around how they, and indeed other patients, should know and be known by the doctor. The information the doctor should legitimately hold was discussed as being on a 'need-to-know' basis and was related to the nature of the health problem and general circumstances at hand. For instance, for ailments considered minor and commonplace, such as having a sore throat, it was not deemed necessary for the doctor to hold much information about the patient or for there to be an interpersonal connection. For more complex problems, such as depressive

illness, the doctor holding information across the three identified spheres of knowledge (individual, family and social), and the existence of such a connection with the doctor, were thought to be at a premium. The level and type of knowledge the known doctor should hold, therefore, usually was expressed as being contingent upon the nature of the health problem and patient's circumstances. Limits were also placed by patients around how the patient and doctor know one another socially through reference to the importance of keeping an 'appropriate' social distance.

Further, the dis-benefits of being known 'too well' were noted by patients. Over-familiarity was perceived as potentially leading to the doctor having a narrow view of the patient, making incorrect assumptions, and possibly to misdiagnosis. Patients could also be discouraged from consulting the known doctor about an embarrassing or intimate problem in order to be protected from the emotional turmoil associated, for instance, with gynaecological examinations. This was particularly noted as an issue of gender. Patients also avoided seeing the known doctor for fear of disrupting how they were seen by and, thus, their relationship with, the doctor. At times, and for these reasons, complete anonymity was preferred, for instance, when women choose to attend a Well Woman clinic about gynaecological problems rather than consulting the known male GP.

In Chapter Six, similar to the contingent way patients talked about *mutual knowing*, the data presented show that the importance placed by patients on personal care was not static or universally applied. Patients identified situations

where this was of greatest value, such as in circumstances of high emotional salience, described above. However, they also talked about other situations where it was traded-off against competing priorities and some where it was deemed irrelevant. It was thought not to be a priority or relevant for ailments considered minor and commonplace or for those identified as urgent. In these cases, patients prioritized speed of access to any health care practitioner in order to get a quick 'technical fix' over seeing a particular known and trusted doctor. The perceived need for, and value of, personal care varied according to a given situation and, thus, the importance and value of personal care was context-dependent. The problem of obtaining quick access to a particular, known doctor was more prominent in accounts of patients from large practices and, thus, relatively more trading-off activity was described as occurring in those practices compared to the small.

In short, these data show a complex picture of patients' engagement with the concept of personal care in General Practice, embedded as it is within the wider discourse of bio-psychosocial medicine. Their accounts suggest they regard it as beneficial, and even necessary, to them in certain situations, and that they are actively involved in the discourse's perpetuation. It is described as enabling patients to achieve their own ends; to obtain efficacious medical treatment, speed of access and a sense of security and freedom from pain, and to attend, generally, to the heightened emotions and uncertainty brought to bear by the experiences of ill-health and of health care seeking/receiving. Personal care was expressed as being consciously used to attain the care patients deem necessary in order to sustain their own health and that of their families. Indeed, it was

considered to be of particular importance when carrying responsibility for young children and 'dependent' adults. Simultaneously, patients placed conditions upon, and boundaries around, it and they also, at times, regarded it as irrelevant and problematic, and, sometimes, avoided it.

## **Making Sense of Patient Data: Finding a Conceptual Framework**

### **The Limits of Modernist Perspectives**

The literature review chapter shows that modernist medical sociology has tended to theorize about medicine as an oppressive or disciplining force that is enmeshed in the wielding of power and the maintenance and regulation of social order. Excepting structural functionalism, largely, it has been conceived as a force that, far from being benign, is either consciously or unwittingly harmful. 'Doctor-bashing' is the now well-worn phrase that typifies most modernist perspectives on medicine as a profession and their analyses of the patient-doctor relationship in General Practice, in particular.

To recap the main points of the literature review, the orthodox medicalization critique has accused medicine of individualizing and depoliticizing social issues, of maintaining structural differentiation and supporting established elites. It is seen as dictating what constitutes health and illness, privileging 'expert' knowledge over that of the lay population and extending its sphere of knowledge into all areas of social life in pursuit of self-aggrandizement. Bio-psychosocial medicine, with its emphasis on knowing the whole person, is interpreted as a manifestation of the medicalization of the individual and

society, which deliberately and consciously exercises power. The patient-doctor relationship itself is depicted as culpable in these transgressions and is pronounced to be characterized by an asymmetry of power and conflict, and as supporting the perpetuation of the iniquitous domination of powerful elites over less powerful socio-economic groups.

This critique, as a way of understanding the data presented in this thesis, raises some key issues. First, how can such comprehensively negative theorizing about the role of medicine in society be reconciled with the largely positive way patients talked about personal care in this study? Was patient agency at work in the apparently sophisticated and discriminating ways they talked about personal care as simultaneously beneficial and problematic, both embracing and placing boundaries around the discourse of bio-psychosocial medicine? Was it witnessed in the way they worked at presenting their moral identity to me as an interviewer? Or are these data simply evidence of patients being duped through a state of 'false consciousness' into adopting a dominant medical discourse, on doctors' terms, that serves to control them?

Indeed, the critique leaves the patient with no potential for autonomy to act with agency either against or in concert with medicine. Lupton comments that, from this perspective, the patient is ascribed as being, *'largely helpless, passive and disempowered'* (Lupton, 1997 b: 97). The passivity attributed to people by this perspective is in direct contradiction to the epistemological approach taken in this study. I have already explained in the methodology chapter that the study views people as active participants in social life, whose accounts both reflect and



construct their social reality. The very act of seeking interviewees' perspectives reflects this epistemological position. Placing an interpretation on patients' accounts of personal care as evidence of their unwitting collusion with dominant social forces directly challenges that position.

Further, the critique represents medicine solely as a negative, regulatory and harmful force in modern society. This ignores the benefits that modern medicine has brought by eradicating or ameliorating some illnesses and in its contribution to the relief of pain and distress. This singularly negative view of medicine is a point of concern taken up by some academics. Indeed, Lupton quoting Atkinson notes:

*'... the asymmetry of the [patient-doctor] relationship is exaggerated to the point that the lay client becomes not the beneficiary but the victim of the consultation'* (Lupton, 1997 b: 97, quoting Atkinson, 1995: 33).

However, the question may be asked as to whether adopting a particular medical discourse, by accepting that of bio-psychosocial medicine or working hard to present a moral identity on doctors' terms, for instance, are the price to be paid for security in health care?

As I outlined in the literature review chapter, the modernist perspective of symbolic interactionism does open the way to an understanding of interviewees' agency. This approach offers the scope to impute agency to people, seeing them as social actors. I noted that it allows an exploration of the practical elements of the patient-doctor relationship, the position of both parties



are given credence and taken seriously, and lay people are presented as experts on their own lives. Through such an analysis, the world which constrains and enables the practice of good primary care can emerge from practical examples and not abstract philosophy. However, I also noted that it offers little or no analysis of power or inequality and how such power is played out in the primary care setting. In the main, interactionism, like the orthodox medicalization critique, has tended to see the doctor as powerful and the patient as powerless. It does not attend to the question of whether patients' adoption of medical discourses may be liberating and/or constraining. Further, like the structuralist perspective, interactionism does not treat the concept of the personal in medical care as a problematic. Examining the patient-doctor interaction and relationship at the micro level, the personal is treated as an implicit and underlying assumption, not as a socially and temporally situated construct.

The post-structuralist work of Foucault *does* treat the personal as a socially constructed concept. Foucault's early writings, particularly *Birth of the Clinic* (1973) and *Discipline and Punish* (1979), are the main texts that outline his thesis of power and the part played by medicine in its manifestation and expression in modern society. Indeed, though providing a distinctive analysis of power as both a productive and oppressive force, this early work adds to the portrayal of medicine as complicit in the exercise of *disciplinary* power.

For Foucault, power is not perceived to be an entity that can be held by one group over another. Rather, power is conceived as suffusing all areas of social

life; what Foucault refers to as the '*micro-politics of government*' (Foucault in Martin *et al.*, 1988). It is exercised through the strategies of examination, measurement and observation by determining what constitutes the established norm and measuring all against this. It decides what does and does not constitute illness, it produces what it is to be a patient and it constructs our experience of our bodies through the '*clinical gaze*'. Medicine is regarded as a site of surveillance that discharges such power directly through the regulation of the body and by encouraging self-governance.

Thus, from this perspective, the position of the doctor is quite distinctive. As Lupton, drawing on Foucault, notes:

*'... doctors are not considered to be "figures of domination", but rather "links in a set of power relations, people through whom power pass[es] or who are important in the field of power relations"' (Lupton, 1997 b: 99).*

The position of the patient here, too, is distinctive. She is produced by this discourse of bio-psychosocial medicine. Her subjectivity materializes through, and becomes the focus of, the clinical gaze. She becomes constructed as person. Generally, she is persuaded that certain ways of thinking, behaving and experiencing are appropriate. By subscribing to the discourse of bio-psychosocial medicine, willingly opening herself to the scrutiny of the doctor, accepting 'expert' opinion and often is herself in search of a medicalized explanation for her concerns, she acts within and as part of medical governance. She is integral to the perpetuation of the discourse that both creates her subjectivity and exercises power through inscription on her body. The exercise

of power is less dependent upon coercion and violence and more on insidious, subtle, all-pervasive forms of persuasion. Nevertheless, it has the function of surveying and administering the bodies of citizens in order to regulate social order.

As I outlined in the literature review chapter, the profession of General Practice has comprehensively adopted the concept of the personal that sits within the wider discourse of bio-psychosocial medicine. Personal care is argued to have become the profession's speciality, demarcating it from other areas of medicine, and the profession is a well-established site for the exercise of disciplinary power. Armstrong (1982; 1984), in particular, has been active in tracing the genealogy of this process, applying Foucault's analysis to General Practice medicine and theorizing about it in these terms. General Practice's emphasis on knowing the patient and encouraging her to disclose information, to open up and reveal her hidden self, may be explained in terms of Foucault's (1978) notion of the '*confessing society*' in which the consulting room is a site of the confessional. As Lupton notes:

*'... in the "confessing society", there is an "obligation to confess": it is generally accepted that people should discuss their problems with significant others, inciting talk rather than "bottling things up"' (Lupton, 1996: 161).*

This is reflected both in General Practice rhetoric about what constitutes good practice and is mirrored in both sets of these study data. Patients are expected to discuss their intimate problems, their feelings and their innermost thoughts. Facilitating the patient to 'open up', to reveal her interiorcity, is the professional

responsibility of the GP. For the patient, 'opening up', in some circumstances, is considered to be the road to a healthier life. Knowing and being known by the doctor, the subject of Chapter Five, are central facets of bio-psychosocial medicine and are inherent to the confessional society. Within this perspective, patients' general adoption of, and willingness to engage with, the discourse of personal care in General Practice medicine, witnessed across these study data, would be interpreted as empirical evidence of patients' unwitting complicity in perpetuating the discourse that both constructs and disciplines them.

However, again, this analysis raises many of the same issues about the interpretation of the study data as the orthodox medicalization critique does. It also takes a unilateral view of medicine as a regulatory force that controls social order through the disciplining of the bodies of citizens. It does not take account of what medicine has offered to the individual and society in terms of improved health and relief of pain and distress. Indeed, it leaves no scope for the phenomenology of the body and the potential for comfort in care. Further, the patient is imputed with no ability to act upon the strategies of power or to consider the role she plays in implementing or rejecting a particular type of subjectivity. Thus, the patient is, once again, imputed with a passive role in medicine, as a docile supplicant, duped into collusion with the *disciplinary* exercise of power.

Numerous scholars have raised the same criticisms about the early work of Foucault, arguing that too much emphasis has been placed upon the passivity of

the patient (May, 1992; Lupton, 1996 and 1997; Moss, 1998). Moss comments, for example, that:

*'Foucault was thought to have overstated the extent to which individuals could be "subjected" to the influence of power, leaving them little room to resist' (Moss, 1998: 1).*

They point out, however, that Foucault's later work tackles many of these issues, including questioning the view that medicine is purely a regulatory force and that patients are passive victims of medical power. Foucault's later work attends to these fundamental issues and provides a more adequate way to interpret these complex data, which show patients engaged with, found value in and, simultaneously, problematized personal care. Indeed, these multifaceted data are difficult to explain conceptually with reference to most previous sociological theorizing, and it seems clear that a new theoretical understanding needs to be brought to bear on them. What is required is a framework that encompasses the possibility of people's understandings and experiences of care both as beneficent and problematic, and that allows them to actively engage with and against medical power. I, therefore, have turned to the later work of Foucault.

### **The Promise of Foucault's Later Work**

Foucault's later work on the technologies or practices of the self (1986, 1988) is proposed as a more adequate way forward in understanding these complex data. This work developed and refined his earlier theorizing of power described in *Birth of the Clinic* (1973) and *Discipline and Punish* (1979) and

responds, to some extent, to the criticism that it denies people's ability to reflect on and react against strategies of power, thus playing a part in the construction of their own subjectivity. In short, in reference to his thesis of governmentality, Foucault came to concede:

*'Perhaps I've insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of self' (Foucault in Martin et al., 1988: 19).*

In his later work, he traces the philosophical tenets of Greco-Roman and Christian traditions which emphasize the care of self adopted by modern Western cultures. He concludes that in ancient times, *'... taking care of oneself not only constituted a principle but a constant practice'* (Foucault in Martin et al., 1988: 21) and this has been adopted in modern Western societies. In this analysis, Moss (1998) notes that he particularly draws on Kant's recognition of the part played by human freedom, *'... in this case the freedom to reflect on and potentially change aspects of the self'* (Moss, 1998: 5). He, thus, came to theorize the self as taking different forms and the self as an entity that can be rejected. In the modern world, the techniques of verbalization, of self-disclosure, are used to positively constitute a new self. Foucault acknowledges in this later work, then, that the individual plays a part in the formation of her personhood, the construction of her own subjectivity, and, thus, that her identity is reflexively created. By developing further this theme of the individual's action in response to strategies of power, he was concerning himself with the practices of power at

the level of micro-politics and attending to the phenomenology of power relations.

Little empirical work has been undertaken that focuses on the phenomenology of power relations, that is, how individuals react to, and participate in, strategies of power and accept or reject a certain subjectivity that forms their personhood. Three examples that have been undertaken on the subject are the studies of McIntosh and Bloor (1990), Murphy (2000) and Lupton (1996, 1997 a and b). They are worthy of brief discussion here because of their similarity to the data of this thesis and the way the authors have conceptualized their findings.

The work of McIntosh and Bloor drew on the later work of Foucault to show how patients resisted the surveillance of staff within a therapeutic community and of health visiting staff at home by employing certain techniques. *'Collective ideological dissent', 'individual ideological dissent', 'non co-operation', 'escape' or 'avoidance' and 'concealment'* constituted the forms of resistance against strategies of power they identified. Clients/patients in the studies were effective, at one and the same time, in appearing to be compliant in their relationships with health care professionals, whilst actively resisting their dictates and expectations:

*'The most common form of resistance... was concealment. The advantage of concealment as a technique is that it neutralises the potential for the exercise of power without explicitly challenging it in ways that would lead to penalties' (McIntosh and Bloor, 1990: 176).*

The more recent work of Murphy, too, explored how mothers talked about their infant feeding practices in these terms. Murphy focuses on how, over a period of three months from birth, mothers often moved from unquestioned acceptance of expert advice to breastfeed their babies to an out-right rejection of it. She discusses how, like so many other socially constructed 'truths', the advice to breastfeed is drawn from actuarial calculations that underpin much of public health and is enmeshed in a discourse of risk. Mothers who do not carry out this advice 'put their babies at risk' and, by so doing, jeopardize their moral identity. Indeed, she comments that:

*'The injunction to breast-feed is one more way in which the "good mother" is constructed and promulgated in and through the medico-scientific literature. Discourses around infant feeding reflect and reproduce an ideology of motherhood, within which it is mothers who are ultimately held responsible for how their children turn out' (Murphy, 2000: 295).*

Murphy draws on Foucault's theory of governmentality, seeing infant feeding practices as one example of how:

*'... expertise is central to power relations, mediated through the women's practices of self-subjection and self-government' (Murphy, 2000: 318).*

However, she demonstrates how these women acted upon this discourse and actively participated in the construction of their own subjectivity. By using accounts, such as privileging their own 'inductive knowledge' of their baby over that of the experts and attributing their behaviour to 'extreme circumstances', to 'physical incapacity' and to the 'fault of others', the women explained their



behaviour and resisted being defined as irresponsible or imprudent. In short, Murphy shows the women were not passive recipients of expert advice, often rejecting it in favour of their own knowledge, but recovered their moral identity by implementing strategies which preserved their status as good citizens and competent mothers.

Lupton has also raised questions about the potential for individuals to work with and against dominant medical discourses in a way that demonstrates agency, and she has sought to understand her data through reference to the later theories of Foucault. In a qualitative study of patients and service providers in Sydney, Australia, she explored the emotions inherent in the patient-doctor relationship and in the experience of illness. Her findings, which she reports in a number of papers (Lupton, 1996; 1997; 1998), are strikingly similar to those of this study, in the sense that patients engaged with the discourse of bio-psychosocial medicine:

*'... the majority of lay people interviewed continued to want to invest their trust and faith in their doctor, and welcomed the doctor showing an interest in their lives including their personal lives. For those people who had experienced serious illness or hospitalization, it was vital that they could rely upon their doctors' (Lupton, 1997 b: 105).*

However, simultaneously, they problematized this. They talked, at times, about wanting to dominate the doctor and to act as consumers of health care, and as expressing the investment of trust and faith in the doctor as potentially problematic because:

*'... it means relinquishing some degree of autonomy, allowing oneself to become dependent upon and exposing one's body, feelings and innermost thoughts to another. In the relationship between carer and cared-for, there is continual tension on the part of the cared-for between wanting and appreciating care and resenting it' (Lupton, 1997 b: 105).*

Lupton concurs that neither the orthodox medicalization critique nor the main body of Foucault's work reported in this thesis provide adequate explanations for these data. Rather, she also concludes that Foucault's later work on the technologies or practices of the self offers a better way of understanding them. She interprets the study data as showing that those patients who present themselves as compliant, willing to enter into a relationship with the doctor and to accept her medical advice need not be viewed as passive and docile subjects of the medical gaze, but as:

*'... actively engaging in practices of the self, that they consider are vital to their own well-being and freedom from discomfort and pain' (Lupton, 1997 b: 106).*

Other patients present themselves as 'ideal-type consumers', who reject engagement with the doctor in this way. Many pursue both types of subject position at the same time, demonstrating that people reflexively adopt or reject a certain subjectivity, depending on the circumstances at any given time. Subjectivity, then, should be understood as '*dynamic and contextual*' and not as static. As noted at the outset of this chapter, Lupton concludes:

*'... hegemonic medical discourses and medical practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximize their health*

*status and avoid physical distress and pain'* (Lupton, 1997 b: 94).

She further notes that little empirical work has been undertaken that explores the phenomenology of power relations and, to remedy this, recommends that:

*'... scholars and researchers devote more attention to the ways that discourses on the human body... are recognized, ignored, contested, translated and transformed in the context of everyday life'* (Lupton, 1997 b: 108).

This thesis responds to that conclusion and recommendation. It, therefore, differs from previous work in this field, some examples of which I have just summarized, by focusing on General Practice in a UK context, and by taking account of the recent and proposed policy developments of health services in that context. It is also distinguished by examining the meanings patients and doctors attribute to the concept of the personal in care and the importance and value it holds for them in everyday circumstances. Further, it is distinctive in comparing the accounts of patients and doctors and by the inclusion of the variables of practice size and deprivation score in examining the concept of the personal in care. It is in the light of this previous work, and the particular contribution of the focus of this thesis, that I now wish to return to a discussion of my own study data.

### **Fulfilling the Promise: Foucault's Later Work**

These study data clearly suggest that patients adopt and engage with personal care as a concept that is embedded in the wider discourse of bio-psychosocial

medicine that, undoubtedly, is a strategy by which patients may be surveyed, their subjectivity constructed and *disciplinary* power exercised. However, patients talked about entering into the relationship with the doctor, being anything from compliant or accepting to expectant and even eager that the doctor hold contextual knowledge about them in a, largely, positive way.

In concert with Lupton, I contend these data show that patients, at times, actively adopt and participate in the personal care relationship in pursuance of having their health care needs met. The numerous specific benefits patients ascribed to seeing the known doctor provide clear evidence for this. The benefits were seen as ranging from enabling them to more easily consult, gain access, fully participate in the consultation, raise difficult issues of concern and negotiate the wanted outcome, and were attributed with improving medical outcomes and supporting the maintenance of patients' health and that of their families. Patients noted being enabled to develop the trust in the doctor that was thought essential to their health care, especially during the most difficult and uncertain of times. Bio-psychosocial medicine, with its embrace of the personal, may be a strategy of power, but it is one that is actively engaged with by patients to achieve their own objectives and maximize their own and their families' health. In this sense, patients' engagement with the discourse of bio-psychosocial medicine may also be a strategy by which they are liberated from uncertainty and any pain and distress they may suffer.

Patients stated that they often wanted to be known by the doctor, but the crucial point to emerge from these data is that they wanted and worked toward being

known in a *particular way*. Personal care may have constructed the patient as person, but it also enabled them to be known as a certain type of person. The theme of having a moral identity, its importance in terms of receiving good health care, patients' concern to ensure its construction and preservation in the face of an ever-present threat to its continued existence suffused these data. Indeed, patients were active in directing and placing boundaries around how health care professionals know them. They believed the personal care relationship allows them to construct and maintain an identity as legitimate and deserving patients and as competent and trustworthy people and parents. They connected this way of being known to obtaining the health care they need and want, offering further evidence that they engage with the discourse of personal care in a way that enhances their own position.

The boundary work they performed in order to achieve and maintain this identity shows the strategies employed generally in patients' work to act upon and create their subjectivity. They did this through placing conditions upon, and circumscribing what and how, the usual doctor knows them and, sometimes, choosing to consult an unknown practitioner, depending on context. Indeed, patients placed boundaries around the type of information the doctor needed at any given time, making it contingent upon the nature of the problem to be addressed. They chose to consult a particular doctor who had wider knowledge, and, perhaps, an interpersonal connection with them, for certain types of problem and to see someone unknown for others, as this limited how they were known and preserved their particular identity. This boundary work is testament to the postulation that, while power may be inscribed upon the

body of the patient, it is also subject to what Foucault calls a '*counter-attack in the same body*' (Foucault, 1980: 56, quoted in Lupton, 1997 b: 102). It evidences that patients are not docile bodies whose subjectivity is imposed by medicine, but that some degree of autonomy is possible and can be exercised through these various strategies.

In other words, patients described acting within and against the discourse of bio-psychosocial medicine to maintain a particular subjectivity and to create this particular subjectivity for their own purposes. The emphasis patients placed on establishing and managing their moral identity reveals how patients act to construct their subjectivity with awareness of predominant cultural values. It is perhaps not insignificant that the attributes of legitimacy, competence and trustworthiness are especially emphasized in the context of a social and organizational backdrop that constantly brings into question the patient's morality, treating her as potentially problematic; as '*demanding*', a hypochondriac and time-wasting (May and Kelly, 1982; O'Dowd, 1988; Fineman, 1991; Rogers *et. al.*, 1999). Indeed, the spectre of the problematic patient was invoked in these study data, with the discourse of the '*heart-sink*' patient regularly being employed by the doctors interviewed.

Patients' efforts, too, in the context of the research interview to construct and present themselves as having a moral identity through their use of the rhetorical device of being other than those who are abusive, manipulative and, in effect, illegitimate and untrustworthy, support this contention. Thus, it was not only doctors who raised the image of the problem patient, but also patients who

worked to distance themselves from that negative identity. Focusing on moral identity, in particular, indicates that people may not be entirely free to construct their subjectivity without reference to these dominant cultural norms and outside the discourses and subjectivities that are culturally available to them.

However, there is evidence that patients work hard to construct and present their subjectivity, albeit from these available discourses. Patients' attendant circumstances at any given time were cited as being influential in this.

Depending on these circumstances, they variously constructed themselves as 'personal care patients', eager to consult the known doctor, as well as, what might be called, 'consumerist patients', where speedily accessing any health care practitioner for a technical 'quick-fix' is prioritized. This may be regarded as the '*art of existence*' that Foucault (in Martin *et al.*, 1988) referred to, which individuals employ in order to transform themselves. Engaging with, placing conditions upon and boundaries around, and resisting the hegemonic discourse of bio-psychosocial medicine demonstrate patients' reflexivity in this respect.

Lupton's point that patient reflexivity is situated in the lived experience of the body is testified to by these study data through the attention paid to emotion. For example, it is present in the talk about the feelings incited by ill-health, by caring for others and by the acts of seeking and receiving health care. It is also evident in the emphasis placed on the interpersonal knowledge between patient and doctor, and the significance patients attributed to the *experience* of care and not just *medical outcomes*. Indeed, patients talked mainly in phenomenological terms about health care and its place in their everyday lives. Their emotional



state was frequently connected to how they engaged with or acted against personal care. For instance, when dealing with an intimate, embarrassing or worrying problem, and their relationship with the doctor was considered to offer this type of support, patients preferred to see the known doctor. When concerned that exposing themselves to the known doctor, either emotionally or physically, would cause them distress or jeopardise how they were known, they rejected this in favour of seeing an unknown doctor. This reveals the extent to which people are not just constructed in and through, but actually experience, the lived body. Lupton quotes Schiller, who makes the same point:

*'... it is necessary to allow for the lived body, for the phenomenology of the body. Bodies may be surrounded by and perceived through discourses, but they are irreducible to discourses. The body needs to be grasped as an actual material phenomenon which is both affected by and affects knowledge and society'* (Lupton, 1997 b: 103, quoting Schiller, 1991: 664, emphases in the original).

In this light, engaging in the discourse of bio-psychosocial medicine, willingly entering a relationship with the doctor in which the patient's interiority and wider context are known, should not be interpreted as her docile and passive compliance with a strategy of power that compels her to open up to the scrutiny of the doctor and, so, collude in governmentality through surveillance of her body. Nor should it be regarded as dictating her subjectivity, as imposing a construction of self on her of 'patient-as-person'. These data suggest that patients participate in this discourse in an effort to achieve their own ends, principally to maximize their health status and that of their families and to be liberated from uncertainty and any pain and distress she may face. The



boundary work they engage in reveals they are not simply recipients or victims of medicine, but react against strategies of power and are reflexive in the formation of their personhood, again, to enhance their own position. Personal care, then, has a dual function, simultaneously acting as a strategy of power and as a means by which patients may grasp freedom.

So far in this discussion of how a conceptual understanding of these complex study data can be brought to bear, I have referred mainly to patients' data. I now wish to discuss doctors' data, as these, too, illuminate the complex ways in which personal care was talked about as both beneficial and potentially problematic. They contribute further to an understanding of how people respond to strategies of power and their subjectivity is reflexively constructed. They also highlight that personal care, embedded in the wider discourse of bio-psychosocial medicine, is used by doctors to perform a dual function; one that is both liberating and controlling.

## **Summary of Doctor Data**

Like patients, doctors' data show the extent they subscribed to, and spontaneously talked about, personal care. Throughout the interviews, doctors spoke with notable enthusiasm and feeling about the topic. In Chapters Four and Five, their construction of the concept of the personal was shown to be consistent with patients'. Indeed, personal care was also discussed by them in terms of the discourse of bio-psychosocial medicine, with its emphasis on the whole person and on providing individually-tailored care. It was regarded as the *raison d'être* of General Practice, the reason for them having chosen this area

of medicine, and they equated it to what constitutes good medical care. *Mutual knowing* and *mutual trust* also featured prominently in their accounts as key characteristics of such care and they talked at length about their efforts to get to know their patients and, so, to forge this trust.

In Chapter Six, data show that doctors placed significant importance and value on personal care and identified similar benefits for patients. These were linked thematically to the patient's *experience* of seeking and receiving health care and to improved *medical outcomes*. Specifically, doctors noted that patients could more easily access care, were enabled to more fully and equally participate in the medical encounter and, were more empowered through this approach to medicine. A quick and accurate diagnosis could be more readily achieved and efficacious treatment given with less recourse to intrusive, unnecessary and potentially harmful medical tests and procedures. Doctors reported that, through knowing the patient, they could live with a greater degree of uncertainty, a higher threshold of risk, and, so, reduce patient medicalization. Thus, personal care was talked about as potentially enabling doctors to extend the beneficence of care and to liberate patients from their ill-health, distress and pain.

Two distinctive benefits of personal care mentioned by doctors, not present in patients' data were, first, that providing such care gave doctors occupational satisfaction and, second, that it aided patient compliance and supported doctors to manage, in particular, the problematic patient. Indeed, on the latter point, the data show that doctors saw great benefit in giving personal care to patients who

had complex and long-term problems, were difficult to engage or resistant to being known by the doctor, and who might 'abuse' or be 'manipulative' of the system or individual doctor. The doctor, and the practice as a whole, could better monitor and manage such 'deviant' patients. In this case, the sharing of patient information both formally and informally amongst practice staff, including reception staff, was deemed useful in exercising such control.

A further distinctive point between the two sets of data is that most doctors did not consider that the level or type of information they hold about the patient should be context-dependent. They mainly regarded it as relevant, regardless of the nature of the specific problem they were being consulted about. They invoked the notion of banking any information gleaned even during a consultation for a minor, self-limiting illness and their descriptions suggest it is perceived as an investment in their relationship with the patient for the future.

Thus, it is clear that doctors in this study clearly adopted and engaged with the bio-psychosocial discourse of medicine and found it of great value both for their patients and themselves. However, like patients, doctors also talked about it problematically. In Chapters Five and Six, doctors stated that bio-psychosocial medicine provides them with occupational satisfaction and, simultaneously, places high demands on their personal resources and creates high levels of stress. The personal cost to them of trying to give personal care was discussed in terms of potentially resulting in burn-out. This was described as leading doctors to carry out their own boundary work with patients around this discourse. They noted that, when feeling exhausted, they would avoid

engaging the patient in opening up about more difficult issues or, if raised by patients, they may resist hearing the information and dealing with the problem there and then. Doctors also sought to maintain a social boundary around how they know and are known by their patients, circumscribing the relationship by being professional and friendly in their approach but, usually, not to being friends.

This boundary work was also expressed by doctors in terms of the problems personal care might pose for patients. Personal care was thought to potentially cause them the dis-benefits if these boundaries were breached. Over-familiarity could result in the doctor having a narrow or complacent view of the patient, pigeon-holing the patient and making an inaccurate judgment based on previous experience of her or her family. It was noted that *'familiarity can breed contempt'*. It was also thought to potentially result in the patient's over-dependency on the doctor. Further, doctors wrestled with the problem of circulating patients' information amongst practice staff and other health service providers, anxious this may breach their ethical duty to preserve patient confidentiality and fearing for any negative consequences for patients of being known more generally by staff in a negative way.

Thus, the same question as was raised about patients' data may be posed about doctors' in terms of how these can be understood theoretically. Doctors' data raise the same issues about the extent to which doctors are constructed through, and constrained by, dominant medical discourses, such as bio-psychosocial medicine? The data reveal that doctors, simultaneously adopt, and yet place

boundaries around, and sometimes even resist, the discourse and practice of bio-psychosocial medicine with its embrace of the personal. They regarded it as valuable as well as potentially problematic to themselves and their patients; they talked about practicing it to both empower and liberate patients from ill-health, pain and distress, but also to identify and exercise control over the problematic patient.

## **Making Sense of Doctor Data: Finding a Conceptual Framework**

### **Foucault and Other Post-Modern Perspectives: The Further Promise**

In dealing with the questions raised about how to interpret doctors' data as pertained to patients', I turn again to the later work of Foucault. Whilst doctors are theorized as *'links in a set of power relations, people through whom power passes'* (Lupton, 1997 b: 99), this study evidence suggests that they, too, exercise some autonomy in how they engage with and react to this dominant medical discourse. It seems that they should not be regarded merely as impassive purveyors of this governing strategy. They appear to adopt it variously: to empower patients in the consultation and over the process of their care, liberating them from the burden of ill-health, of pain, distress and uncertainty (as patients themselves described), and to exercise discipline over patients; by constructing their subjectivity, 'knowing' them as legitimate and trustworthy or as abusive and manipulative, influencing their experience of illness and encouraging compliant behaviour through doctors' participation in a network of surveillance and management.

Further, doctors' own subjectivity seems to be constructed through the adoption of this discourse. It is embedded in their professional rhetoric as a mark of the good doctor and demarcates their identity from those in other areas of medicine. That the construction of the patient-as-person, which is inherent in the discourse of bio-psychosocial medicine, also produces the doctor as sentient being is evident in these data, and is a point taken up in Armstrong's theoretical work. For instance, Gothill and Armstrong (1999) contends that, in tracing the genealogy of the development of the patient-as-person, one can also discern the emergence of the '*doctor as human subject*' (Gothill and Armstrong, 1999: 1). Just as the discourse of bio-psychosocial medicine has produced the patient as experiencing individual, so has it required the doctor be placed under the same scrutiny and become reconstituted as '*an embodied and vulnerable individual*' (Gothill and Armstrong, 1999: 1). Yet, at times, when being the personal care doctor is too onerous and threatens the doctor's physical and emotional health, it can temporarily be laid aside. The doctor's subjectivity, then, appears also to be created through this medical discourse, but this empirical evidence illuminates the ways in which the doctor is active in engaging with and against this strategy of power, with varying effects.

The theoretical work of Fox (1993; 1995) is also helpful in developing an understanding of the doctors' data. Fox's work suggests that bio-psychosocial medicine as a dominant medical discourse is acted upon by health care professionals with the dual effect of liberation and control. He draws on the work of Foucault and the post-modern theorists Derrida and Cixous to explore how the caring relationship can be understood both as care-as-discipline, the

*'vigil of care'*, and the *'gift of care'*, which is mediated by *'love, generosity, trust and delight'* (Fox, 1995: 108). He expresses concern that medical sociology has focused too greatly upon the dominance and control in the care relationship to the exclusion of a more optimistic view of care as potentially *'resistible'* and beneficent.

His argument begins that, within this framework, care-as-vigil and care-as-gift cannot be understood as emanating from an essentialist perspective, as there is no essential self, nor used to challenge dominant institutionalized forms of social control, as power is theorized as disciplinary, and so as pervasive, operating at the micro-level of encounters. If subjectivity is indeed the outcome of power/knowledge, then care-as-vigil and any resistance to it, the care-as-gift, operate within the same domain of language and may be witnessed in the everyday contact between the carer and cared-for. He argues that these dual aspects of the care relationship sit side-by-side with the inevitable and constant possibility of the one being transformed into the other.

In the notion of the vigil of care, Fox mirrors the theorizing of Foucault and defines this as:

*'... the continual subjugation of care's clients and, increasingly, all aspects of the environment in which they live to the vigilant scrutiny of carers, and the consequent fabrication and perpetuation of subjectivities as 'carer' and 'cared for' ' (Fox, 1995: 112).*



He notes that not only is the profession of care fabricated through cultural discourses but so are its clients/patients. He concurs, then, with the views of others whom I have discussed in this thesis (Armstrong, 1979, 1982, 1984; Lupton 1996, 1997 b; Gothill and Armstrong, 1999) that, for example, patient-centredness, while offering an alternative to medico-centred care, is still a means by which the medical gaze is extended and the vigil exercised.

Fox agrees that the early work of Foucault may be rightly challenged for focusing on the *'totalizing effects of power'* and, so, imputing the body as a docile and passive subject. He challenges Foucault on the grounds that it denies the possibility of the subject resisting such power by breaking through discourse. He turns, instead, to the work of the Feminist post-structuralist, Cixous for exploration of this. He reports that Cixous partly draws on Derrida, who considers that the *'undecidability'* of, and *'différence'* in, language offer the possibility for resistance to a discourse that constructs and produces subjectivity. As I discussed in Chapter Four, the *'undecidability'* of language refers to the continual deferral of meaning, the *'slippage of language which occurs as soon as one tries to pin a concept down'* (Fox, 1993: 7). *'Différence'* inevitably arises when using a language or, for that matter, any other symbolic mode of representation in which signifiers can refer not to an underlying reality, but to other layers of signifiers. He concludes that:

*'Because of this undecidability, no discourse can claim absolutely to represent the world: there is always the possibility of other interpretations, and which interpretation is accepted is more to do with power than with accuracy of truthfulness'* (Fox, 1995: 116).



In relation to health care, Cixous distinguishes 'gift' relationships from those she terms '*proper*'. Proper relationships are characterized by property, propriety, possession, identity and dominance. Gift relationships, on the other hand, are typified by attributes, such as generosity, trust, confidence, benevolence, patience, delight, esteem and admiration. Proper care deals with the realm of the possessive relationship. It requires the patient to adopt certain behaviours, to repeat the patterns of those cared for before them and it maintains the distinction between the cared-for and carer. It relies on the 'professionalization' of care, the systematizing and standardizing of the care regime in evidence throughout twentieth century medicine and allied professions. Care as gift, on the other hand, allows and supports the cared-for the space to be an individual, to influence her own subjectivity, not in the sense of reacting against the oppressive and subject defining nature of care, but when cared for within a regime that is characterized by an '*enabling investment*' (Fox, 1995: 117). Fox uses these distinctions to conclude that the language of care-as-gift may be used to substitute care-as-vigil. I will return to this important point later when discussing recent policy developments in primary care.

The epistemological axiom of human agency is premised on the belief that language is not absolute and, thus, there is always the possibility of subverting, rejecting and transforming discourses that seek to discipline and control. In this postulation, Fox concurs with the work of Murphy (2000) and Lupton (1996), described above. He takes his thesis further, though, in emphasizing that, through language, the vigil-of-care has the potential to be transformed into the

gift, not only by patients' responses to a dominant medical discourse, but by care-givers investing their 'generosity' to enable the cared-for to resist the power and knowledge that subjects them and to create a new subjectivity or, what Fox refers to as the capacity to become 'other'.

Indeed, this approach to language has been explored by others, such as Abu-Lughod (1989) and Tsing (1994), who discuss the subtle forms of resistance possible through working around the discursive spaces that exist between discourses or, what Tsing calls, 'margins':

*'Margins, in this use, are sites from which we see the instability of social categories... My interest is in the zones of unpredictability at the edges of discursive stability, where contradictory discourses overlap, or where discrepant kinds of meaning-making converge; these are what I call margins'* (Tsing, 1994: 279).

The evidence of this study is that, like patients, doctors also use the spaces between discourses to achieve various ends. Doctors simultaneously extend the beneficence of care through the discourse of bio-psychosocial medicine to empower and liberate patients from pain and distress and use it to identify, survey and control the problematic patient, to act as 'Big Brother'. They willingly subscribe to this discourse, but are also aware of its shortcomings and potential problems. They eagerly adopt it but, at times, resist it when it draws too heavily on their personal resources.

Indeed, the doctors' data in this study provide evidence that personal care, embedded in the wider discourse of bio-psychosocial medicine, represents a

vehicle by which the vigil of care is exercised. This is evident in doctors' accounts that fabricate good and abusive patients and that tap into and promote a wider, controlling discourse on 'appropriate' use of services. It is also evident in the degree of acceptance shown of the doctor's 'rightful' sphere of knowledge and influence extending into every corner of the patient's life patient, which embroils patients in working hard to maintain the former identity and avoid the latter. It also is evident in the explicit use of personal care to survey and control the problematic patient.

However, these data also provide testament to the presence of the gift-of-care. Doctors spoke with feeling about General Practice as a vocation, their personal and heart-felt commitment to their patients, their concern to do the best possible to relieve patients' anxieties and suffering, their willingness to connect emotionally and share moments of great significance in their lives, and of being with them. They related doing this, what one doctor called '*going the extra mile*' for the patient even when they felt exhausted and unable to deal with any more human pain and stories of tragic lives. That these accounts of humanity, compassion and beneficence are credible as descriptions of, at least, one aspect of the caring relationship are testified to by the parallel accounts from patients, which were suffused by equally compelling stories of the doctor '*being there*' for them, of connecting with them at an interpersonal and human level, and of the significant value they placed on their care.

That personal care, embedded in the discourse of bio-psychosocial medicine, is a site in which power is exercised, is a vigil of care, that controls and literally

*subjects* patients, cannot be denied. But, these data also suggest that through both patients' capacity to act within and upon a dominant medical discourse and doctors' capacity to work with generosity within this discourse, the caring relationship may be, at times, transformed from a vigil into a gift-of-care, which offers freedom from human suffering.

## **Policy Implications**

### **Introduction**

In the introductory chapter, I discussed the policy context of this thesis that explains the background to, and motivation for, the study being undertaken. I summarized the main policy shifts that have given rise to general concern within academic and medical practitioner communities that the potential for personal care is being eroded, with some writers predicting the imminent death of the personal doctor. I now wish to return to these policy developments and consider them in the light of this study's findings and also with reference to the sociological discussion above. I consider them particularly in relation to the Scottish (Scottish Executive, 2001) and English (Department of Health, 2000) NHS plans and the proposed new GP contract that, if adopted, will contribute to setting the framework for primary care services at the start of this new millennium.

### **Recent Policy Developments**

To recap, the Scottish and English NHS plans drive forward many of the policy shifts thought to threaten the survival of personal care. These include: emphasis on speed of access to any health care practitioner (Scotland) and the first available GP (England) within forty-eight hours; emphasis on access to services outside normal surgery hours; the growth of practices and of multi-professional teams; multi-team management of chronic health problems and the resultant diffusion of health care tasks across a number of practitioners; GP specialization;

a focus on a public health agenda in primary care; and the setting of national clinical standards taken forward by the regimen of Clinical Governance through Evidence Based Medicine (EBM).

These developments sit alongside and are intertwined with the traditional values usually associated with personal care, such as personal continuity, patient-centred medicine, the patient as whole person, and also with clinical autonomy and service to the local community. The emphasis on speed of access to any health care practitioner is not discussed as being prioritized to the exclusion of a patient's opportunity to see a known doctor. Also, patient-centred care is described in the plans as eliciting the expressed needs and preferences of the patient, and these are to be at the centre of the planning, organization and delivery of health care. The plans further note the need to preserve clinicians' right to autonomy to prescribe what is right for individual patients within a framework of national guidelines and standards. A public health agenda, reflected in these national standards, is to be implemented at a local level in order that account is taken of the specific needs, current and future, of local populations and communities. Particular attention is to be paid to the issue of health inequalities in those communities.

The proposed new GP contract was also described in some detail in Chapter One. In essence, the contract embraces and, if adopted, would also take forward many of the commitments contained in the NHS plans by means of a national system of rewards and incentives. These include improved access to practitioners outside normal surgery hours, a multi-professional, integrated

approach to care, GP specialization and a managed system to improve country-wide standards. Curiously, however, those values usually associated with personal care mentioned in the plans are absent from the contract. In effect, if adopted and comprehensively subscribed to, it is difficult to imagine how these 'core values', which the NHS plans makes a commitment to, may be retained, far less developed. I now consider these policy developments in light of the study's findings.

## **Policy Developments in Light of the Study Findings**

The findings of this thesis support the NHS plans' stated commitment to retain the values usually associated with personal care, defined here as care given within a patient-doctor relationship built over time, characterized by *mutual knowing* and *mutual trust*, and in which the doctor shows a particular consultation style. It is confirmed that personal care has continuing salience for some patients, at the very least for women with young children in certain circumstances. However, the findings also support the proposals to improve access to primary care services, with certain caveats, and I start this section with a discussion of this issue of access.

Quick access was desired and valued by patients in this study. However, whilst some patients were unconcerned about which doctor they consulted for some problems, ideally, most wanted the choice of relatively quick access to the known doctor during surgery hours, rather than having to see the first available practitioner. In the absence of such a possibility, which was particularly evident in the larger practices, most patients discriminated between those situations in

which any practitioner would do and those where waiting to consult the known practitioner was preferred. In the current policy context, this means that patients in larger practices have to participate in more 'trading-off' activity than in the smaller. This, in turn, depends on the perceived nature and urgency of the problem. In the smaller practices, the result of trading-off is that patients are more likely to get to know all the doctors fairly well. As the push for more large practices continues, the difficulty of patients seeing a known doctor when they wish within a reasonable timescale is likely to be exacerbated.

As discussed in Chapters Five and Six, the importance of seeing a known practitioner was contingent upon the patient's circumstances and her perception of the problem at any given time. The importance and value of personal care were context-dependent. Patients' priorities changed depending on attendant circumstances, a conclusion supported by the empirical work of Preston *et al.* (2001). In circumstances considered urgent or for ailments deemed minor, commonplace and about which there is little ambiguity over the legitimacy of seeking medical advice, seeing the first available practitioner usually was prioritized by patients. In some circumstances, seeing a known practitioner was thought to be irrelevant. In a few others, patients preferred to see an unknown practitioner, such as when seeking greater anonymity for some intimate or embarrassing problems. This was especially noted as an issue of gender.

However, consulting the known doctor was regarded as essential or preferred in many circumstances. These included situations which have high emotional salience for patients, where there is considerable distress and uncertainty, and



also those that may be perceived as illegitimate, too 'trivial' or too far outside the scope of medicine to consult about. Thus, the evidence of this study is that patients value different aspects of care at different times, contingent upon attendant circumstances, and the NHS needs to offer a variety of co-existing models of health care from which patients can choose.

Another main finding of this study is that patients attached great importance to having the option of personal care over, at the very least, an episode of illness, if not over a lifetime. Seeing a known and trusted doctor was demonstrated as having continuing salience for patients. The consumerist patient, defined as only wanting access to twenty-four hour care from the first service provider, also described as Tesco medicine, was not greatly in evidence. Rather, as attendant circumstances dictated the type of care someone needs at any given time, these findings suggest that an emphasis on speed of access to any health care professional should not supersede or replace the opportunity to see, preferably within a short time-frame, the known practitioner.

Supporting the above are the numerous benefits ascribed by both patients and doctors to personal care, which have been detailed in Chapter Six. Interestingly, they include reference to the facilitation of patient's access to medical care through being known. For interviewees, then, speed of access and personal care were not distinct concepts, but inextricably intertwined in the everyday practicalities of using available health services, as they are currently configured. Interviewees also made reference to achieving many other ideals through personal care, such as regarding the 'patient as partner', the patient having some

scope to influence the agenda, to fully participate in the encounter, and to more easily negotiate the preferred outcome. Likewise, patients stated that a major benefit of personal care was the advantage of being dealt with more easily as sentient beings, as individuals whose wider domestic and social circumstances may be taken account of, so that treatment can be properly tailored to meet their specific needs within their specific life context. Interviewees inextricably linked quality of care for some problems to knowing and being known.

The move toward a public health agenda, the setting of national standards and assessment of quality mainly by evaluating the doctor's/practice's adherence to EBM, particularly consolidated by the proposed new GP contract, is out of step with these findings. Financial incentives which are weighted to promote and carry through a public health agenda privilege population medicine over the specific needs of the individual. Lower levels of reward, then, may be provided to those GPs who choose to continue investing in building relationships with their patients, discussing wider issues, sharing significant life events and reducing patient medicalization.

Having said all this, the new GP contract states clearly that it does not penalize practices for patients who refuse or do not comply with such treatment. However, doctors must prove that non-compliance is the fault of the patient and not the doctor. The default position, therefore, is that the patient will subscribe to 'expert' advice and, in the event of this failing, written evidence must be provided to remove blame from the practice, lest it be penalized financially. Within this scheme, patient autonomy and the right to self-determination, when

not congruent with the advice given, would inevitably be construed as a barrier to the advancement of improved practice performance and population health, and doctors may feel unrelenting pressure to encourage patients to conform. Indeed, it may encourage some practitioners to coerce, subtly or otherwise, the patient to subscribe to standardized medical regimes that are not suited to the individual, given her wider circumstances, or desired by that patient at that point in her life. The emphasis, then, may be on the practice of medicine that wields power rather than extends beneficence and the gift-of-care.

The quality markers against which practices are to be measured are predominantly clinically-based and rest within a public health framework. This promotes a technically-oriented, 'lifestyle' changing, population surveillance medicine that reveals the move away from the individualized medicine interviewees in this study valued. It also assumes that the practice of good medicine may best be measured mainly by organizational indicators and clinical outcomes dictated by medical 'experts'. There seems to be little room for patients' conceptions of what constitutes the most important clinical goals for them. Indeed, the new GP contract states that:

*'The markers in the scheme have been chosen by one of the UK's leading quality experts, because they are evidenced-based. Future quality schemes and frameworks will have to offer the same calibre of evidence before they could be included'* (General Medical Council, 2002: 17).

Yet, a primary finding of this study is that patients defined quality of care not only in terms of the organization or by *medical outcomes*, but by the *experience*

and the process of their care. Quality of care is to be defined and assessed by criteria that are perhaps the easiest to measure, but which are not likely to reflect all aspects of patients' priorities or definitions of what constitutes good quality. Indeed, the interpersonal connection between the patient and staff was uppermost in their descriptions of what constitutes good medicine. In addition, as noted above, in the view of many patients and doctors in this study, medical outcomes are inextricably linked to the experience of care and cannot be disentangled from it. Personal care attends to the phenomenology of the illness and care-seeking experience in a way that a medico-centred, public health, evidenced-based agenda may not. Thus, these data support a phenomenological approach to the study of the concept of personal care and to the setting of quality standards, and suggest attention should be paid to the patient's feelings about and experience of care when planning, delivering and auditing services. This is in line with the recommendations of the Research & Development Scoping Exercise on Continuity of Care (NCCSDO, 2001).

The study findings also suggest that knowing the doctor enables greater patient confidence in the medical practitioner and, concomitantly, the diagnosis and treatment given. Many benefits were also noted by doctors, such as greater patient compliance, reduced medicalization and fewer hospital admissions. Confidence was mainly conceptualized in terms of *experiential trust*, which could only be engendered through having a particular kind of contact with one or a small number of practitioners over time. Patients described working hard within existing organizational parameters to see the known doctor in order to build and preserve this trust. All of these ideals and objectives are promoted by

the NHS plans and, it seems, that they may best be retained and met through preserving the patient's ability to see a known doctor, when required.

Policy shifts that encourage a multi-professional approach, the splintering of care tasks and, so, the diffusion of the patients' care across the team are likely to reduce individually-based treatment and these associated benefits and to contradict the stated patient preference of care. Having no option except to see a larger number of relatively unknown practitioners cannot afford the same relationship building potential as a system that preserves the possibility of personal care and also may reduce the level of trust that can be fostered.

Further, in the proposed new context, confidential information will have to be more centrally shared by all staff members. Yet, in this study, seeing the known doctor usually was regarded as aiding the patient to be known in a *particular way*, as a legitimate patient and trustworthy person with a deserving claim to service. This, I have suggested, supports the patient to enhance her position and to maximize her own health status and that of her family. This benefit was linked not only to the factual information held by the doctor, but to the interpersonal connection between the two, that usually only continuity with a carer over time can afford. The emphasis on multi-disciplinary care, if adopted in preference to the reduction or exclusion of personal care, may lead to the patient's increased difficulty in controlling her moral identity, and lead to fewer opportunities to engage with medicine in an active and self-directing way, or to disengage from it by placing boundaries around knowledge.

This contention is supported by the work of Huby *et al.* (1998) on patients with HIV/AIDS in Scotland. As noted in the literature review chapter, she found that people wanted to see the same GP and that the relationship was valued for being familiar and ongoing. Being known by their GP was beneficial in affording patients a sense of control over their care that was lacking when attending a number of different, multi-disciplinary practitioners. It also was described as allowing them to retain a particular identity with their GP in a way that was not possible when dealing with a large number of health care professionals. Again, the evidence of this study is that taking such an approach to care should not preclude patients having the option to see the known doctor.

Interviewees in this study emphasized wanting the patient to be treated as a 'person first' (Adam *et al.*, Forthcoming); that is as a whole person who has a health problem and not as an 'epileptic patient' or a 'diabetic patient' or a 'depressive patient'. Personal care was considered to meet this desire for a humanistic approach. This strongly expressed patient preference does not sit easily alongside a system that is increasingly focused on a public health agenda in primary care and the specialization of services in the community, both of which may result in a focus on the disease rather than the person who has the disease in a real life context. Thus, attention also needs to be paid to how chronic disease management may be improved without losing the focus on the patient-as-person whose ill-health is an aspect of their lives rather than what defines them within health care provision.

Further, whilst national clinical standards must be improved equitably across the UK through managed systems, it seems clear from this study that this should not be done in a way that detracts from the practitioner's use of knowledge of the patient, together with the patient's right to care which is sensitive to her particular circumstances, needs and wants. EMB, for instance, in my opinion, should be treated as a source of information used by the health professional with judgement and discretion, mindful of the characteristics and views of the individual patient, and not as a prescriptive, formulaic response to medical and social problems. This contention is supported by many who promote EBM as an important aspect of General Practice medicine and who do not treat it as mutually exclusive from care with a personal component. They consider, for example, how evidence should include qualitative research on patients' experiences and views, how best to use it as part of a negotiated agreement on care, and how to apply the evidence to the care of the individual patient (Greenhalgh, 1997; Sackett *et al.*, 1997; Rosser and Shafir, 1999).

The development of whole practice care, the primacy of the public health agenda, EBM and the increasing specialization of service provision in primary care, amongst other developments, if allowed to undermine other stated values such as continuity of care and patient-centred medicine, may result in the patient being reconstructed. She may no longer be treated as a sentient being with specific needs, whose wider family and social context are cogent to the consultation, but transformed into the former construction of a bodily receptacle for disease (Armstrong, 1979; 1982; 1984), and one that, in the discourse of public health, is held ultimately responsible for having that disease. Indeed, the



patient may increasingly become one of a larger population, defined by the nature of any potential or actual illness, and in whom that illness must be prevented, detected, measured and treated.

Unless efforts are made to ensure that the concept of the personal is retained in the face of these changes, alongside other stated priorities, General Practice may become increasingly systematized: a culture dictated by the new 'expert' knowledge that occludes the patient's idiosyncratic and individual subjectivity that matters in medical encounters. I contend that, if some of the new priorities are adopted in an unreflective way, they may undermine the patient-as-person and doctor-as-person dyad, the meeting of two sentient beings, and replace it with the 'public health patient' and 'technocratic doctor'. The possibility of those elements usually associated with the concept of the personal in care may be sidelined, and a dehumanized, de-contextualized discourse of 'risk' further extended into the everyday practices of primary care. By so doing, organizational arrangements increase the likelihood of these services offering proper care rather than that of gift (Fox, 1993; 1995), which so many of this study's interviewees valued. Indeed, the patient may become more object than subject and there may be little scope for the patient's 'otherness' that Fox describes as characterizing the generosity of spirit inherent in care as gift.



## **The Final Word**

This seems an unfittingly pessimistic conclusion to this thesis, especially since the findings discussed in the first section of this chapter showed the extent to which both patients and doctors were active and sophisticated in the way they talked about the meaning and importance of personal care. Personal care has continuing salience for, at the very least, some patients and GPs. It should continue to be at the heart of General Practice medicine and the organization of primary care services. The evidence of this study is that patients show much agency, operating within the opportunities and constraints of the services available to them, in order to obtain the kind of care they deem appropriate, including personal care, at any given time. In the larger practices, for instance, patients had to take part in more trading-off activity, but still managed to obtain some degree of personal care. Doctors also showed the generosity of spirit that suffuses their care-giving; their willingness, at times, to 'give of the self' in their encounters and relationships with patients, even when encountering many obstacles and placing excessive demands upon their personal resources.

Indeed, it seems that, whatever the organizational context, patients and doctors may still be able to interact with it to obtain or provide personal care, if this is what they really want. However, organizational arrangements that do not support the continuation of having the choice of such care makes this more difficult, and may well demoralize GPs whose heart lies in providing this type of care. It could also militate against this stated patient preference. If the proposed new GP contract is adopted in its current form, and if EBM is not implemented and practiced in the way proposed by those writers referenced

above, personal care, as constructed by interviewees in this study, may become more elusive to patients when they want it, require greater efforts from both parties to achieve it and penalize doctors who prefer to provide it. This would be an irony indeed, given the much-publicised commitment to listening and responding to patients' needs and wants.

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# APPENDICES



## **APPENDIX A: Patients' Topic Guide**

### **Preamble:**

Brief description of the study and of what involvement means for the patient.

Stress importance of issues of confidentiality and security of information, if agree to take part in the study.

Patient specifically asked once again if s/he still wants to go ahead with participation. Complete consent form.

### **The Practice:**

Check which practice patient is registered with.

Details of attending practice: History of registering with practice? Why do you go there? Any particular reason for this? How long have you been registered at the practice? Who else in family goes there? Why?

What's the practice like? What staff does the practice have? What services can you get there? Can you see any doctor? Is there an appointment system/open surgery? What's it like?

### **The Doctor:**

Which doctor are you registered with? Do you see this doctor? Do you see any other doctor? Do you tend to see one more than any other or not? Does it matter to you which doctor you see? If, so, in what ways? If not, why not? Do you see anyone else at the practice apart from the doctor? If so, who else do you see? What's that like?

### **Meaning of Personal Care:**

When got the letter about the study, did the term personal care mean anything? Do you feel that you get personal care from the doctor(s) you see? What does

that mean to you? What makes a good personal doctor? What makes a bad personal doctor? Can you give an example of a time you feel you got personal care? What was that like?

Do you feel you/your family ever/always get it? Can you describe what a doctor giving personal care is like?

Can you give an example of a time you feel you did not get personal care (either from GP or any other person in the health service)? What was that like? Did it matter or not? What is not personal doctoring? Describe.

### **Importance /Value of Personal Care:**

Is getting what you think of as personal care of any importance to you? Is it of importance to anyone else in the family? Is it ever/always important? Do you think it's of importance to anyone else/all people? Ever/at all times? Are there any benefits from getting personal care? Are there any problems with it?

### **Other Health Services:**

Do you see anyone else about health matters for yourself or anyone in the family? Do they give you what you think of as personal care? Do you want/need it from them? Why? Why not? Can you describe what that's like?

### **Informal Support Network/Domestic Context:**

Do you talk to anyone else, apart from those in the health service, about your own or your family's health? Do you find them supportive or not? Do they give you anything you cannot get from your doctor/practice?

How do you feel you manage with the family's health? Is there anything that would help you more? If so, what? Is there anything that the practice/doctor could do to help you with your own and your family's health?

**Anything Else:**

Now that we have come to the end of talking about personal care in General Practice, do you think that your view of this has altered in any way from when we started?

Is there any other information you think I should have? Do you have anything else to say? Is there anything else you would like to ask?

## **APPENDIX B: Doctor's Topic Guide**

### **Preamble:**

Brief description of the study.

Importance of issues of confidentiality and security of information stressed again.

What involvement means for the doctor and the practice. Check doctor still wants to be involved.

### **Being a GP:**

Tell me a little bit about yourself. What do you enjoy about being a GP? What don't you like about it? What attracted you to the job? What's important to you about the job?

### **Meaning of Personal Care:**

When got the letter about the study, did the term personal care mean anything to you? Exploration of what is understood by personal care: What does the idea of giving personal care mean to you? What does it involve? How is it given? When is it given? Is it always given?

Is it given by staff other than doctors? Can it be given to one patient by more than one practitioner?

Can you give me an example of a time when you've given what you think of as personal care?

Can you give me an example of a time when you've not given what you think of as personal care?

What is not personal care?

### **Importance /Value of Personal Care:**

Is giving personal care important to you as a doctor? Why/why not? Is it always/ever important to you?

Is getting personal care important for patients? Why is it important or not? Is it always/ever important?

Can you give me an example of a time/patient when/for whom it has been important?

Can you give me an example of a time/patient when/for whom it has not been important?

What facilitates you giving personal care? (Organization of practice/policy level/social and family factors)

What hinders you giving personal care? (Organization of practice/policy level/social and family factors)

What are advantages/disadvantages of giving/getting personal care for you and for the patient?

### **The Practice:**

Can you tell me a little bit about how the practice is organized?

What sort of list system do you operate? (Personal list, shared list). Do you have a particular policy on who patients should/can see?

How many staff do you have? What type of staff do you have? Do other staff in the practice give what you think of as personal care? If so, in what situations? If not, why not?

Does the way the practice is organized facilitate personal care? If so, in what ways?

**Anything Else:**

Now that we have come to the end of talking about personal care in General Practice, do you think that your view of this has altered in any way from when we started?

Is there any other information you think I should have? Do you have anything else to say? Is there anything else you would like to ask?

## **APPENDIX C: Information about Participating Practices and Summary of Patients' Details**

**Practice P1:** Small practice with three doctors (one part-time) and one practice nurse. Relatively affluent practice area: Deprivation score of -1.4 and with a low to middle ranking in the Lothian Health Board list of deprivation. All three doctors interviewed. Four patients were interviewed from this practice, as follows:

**PP 01-01:** Mrs. Thomson was in her forties. She lived with her husband and two school-aged children in a privately-owned house in a practice area with a low to middle deprivation score. The material conditions of the home reflected the relatively high socio-economic standard enjoyed by the family. Mrs. and Mr. Thomson had skilled/professional employment. All of the family had been registered with the small practice in the area for several years. No particular health problems were reported in the family.

**PP 01-02:** Mr and Mrs. Uphall were in their late fifties/early sixties. They lived with their late teenage child in a privately-owned house in a practice area with a low to middle deprivation score. The environment of the locale and the material conditions of the home reflected a moderate socio-economic position. Mrs. and Mr. Uphall were retired and had been employed in semi-skilled/skilled work. The family had been registered with the small practice in the area for more than thirty years. Mr. Uphall had suffered from a chronic condition throughout his life-time. His son was reported to have inherited this problem and also to have

experienced growth problems as a child. No other health problems in this family were reported.

**PP 01-03:** Ms. Vickers was in her thirties. She lived with her two school-aged children in a privately-owned house in a practice area with a low to middle deprivation score. The environment of the locale and the material conditions of the home reflected a moderate to good socio-economic position. Ms. Vickers was self-employed in skilled work. All of the family had been registered with the small practice in the area for around five years. Ms. Vickers had suffered from chronic stress due to health and other family-related problems. Her daughter had multiple disabilities due to a serious, debilitating condition suffered from birth, and this presented a daily challenge to the family. Her son had experienced health-related problems, also reported to be related to family stress. No other health problems were reported in the family.

**PP 01-04:** Mrs. Watson was in her forties. She lived with her two school-age children in a privately-owned house in a practice area with a low to middle deprivation score. The general environment of the locale and the material conditions of the home reflected a moderate to good socio-economic position. Mrs. Watson was self-employed in skilled work and about to become employed in similarly skilled work full-time. All the family had been registered with the small practice in the area for more than ten years. Mrs. Watson reported having recently experienced family difficulties that had resulted in a number of stress-related health problems. No particular health problems were reported in her children.



**Practice P2:** Large practice (health centre) with eight doctors and other practice nursing staff. Relatively affluent practice area: Deprivation score of -2.74 and with a low ranking in the Lothian Health Board list of deprivation. Two of the doctors were interviewed. Four patients were interviewed from this practice, as follows:

**PP 02-01:** Mrs. Peters was in her thirties. She lived with her husband and four children in a council-owned house in a practice area with a low deprivation score. The particular locale of the family home, however, had a high level of deprivation and this was reflected in the material condition of the family home. Mrs. Peters had no employment and Mr. Peters was a full-time student. Three of the children were school-age. All of the family were registered with the large practice in the area and had been for several years. Several family members suffered from a chronic health problem and two of the children were identified as having special educational needs, all reported to be a constant source of concern to the family. Mrs. Peters reported having suffered from stress.

**PP 02-02:** Mrs. Quinton was in her late thirties. She lived with her husband and two school-aged children in a privately-owned house in a practice area with a low deprivation score. The particular locale of the family home, however, was relatively affluent and material conditions within the home indicated high socio-economic standards. Mrs. and Mr. Quinton had skilled/professional employment. All of the family had been registered with the large practice in the area for several years. Both children suffered from a chronic condition and this

had been a source of concern for the family for many years. No other health problems in the family were reported.

**PP 02-03:** Mrs. Richardson was in her early forties. She lived with her husband and two school-aged children in a council-owned house in a practice area with a low deprivation score. The particular locale of the family home, however, had a high level of deprivation and this was reflected in the material condition of the family home. Mrs. Richardson worked full-time in unskilled employment. Mr. Richardson had a permanent disability that prevented him from taking up work. All the family had been registered with the large practice in the area for more than a decade. Both children suffered from a chronic condition that had caused the family concern over many years. No other health problems in the family were reported.

**PP 02-04:** Mrs. Smith was in her thirties. She lived with her husband and two school-aged children in a privately-owned house in a practice area with a low deprivation score. The particular locale of the family home, however, was relatively affluent and material conditions within the home indicated high socio-economic standards. Mrs. and Mr. Smith had skilled/professional employment. All of the family had been registered with the large practice in the area for several years. No particular health problems were reported in the family.

**Practice P3:** Large practice (health centre) with seven doctors and other practice nursing staff. Relatively deprived practice area: Deprivation score of 4.25 and with an extremely high ranking in the Lothian Health Board list of deprivation.

One of the doctors was interviewed. No patients were interviewed from this practice due to recruitment problems.

**Practice M1:** Small practice with three doctors (one part-time and one full-time locum) in building with other practices. Share other practice nursing staff with practices in same building. Deprivation score of 1.3 and with a high ranking in the Lothian Health Board list of deprivation. All three doctors were interviewed. Four patients were interviewed from this practice, as follows:

**MP 01-01:** Mrs. Anderson was in her mid thirties. She lived with her partner of a similar age and four school-age children in an area of high deprivation. General environmental conditions in the area were poor, but material conditions in the home were good. Recently, they had purchased their flat from the council. Mrs. Anderson and her partner both had semi-skilled employment. All the family had been registered with the small practice in the area for more than ten years. Their youngest son, aged four, was born premature and suffered from a number of ailments as a baby, including a problem for which he was hospitalized on an emergency basis. Mrs. Anderson herself reported being generally healthy, except for a recurrent skeletal problem treated by her GP. There were no other health problems reported in the family.

**MP 01-02:** Mrs. Brown was in her late forties. She lived with her husband and two primary school-aged children in an area of high deprivation, although the house itself was situated in a relatively less deprived part of the scheme. The family lived in council owned accommodation and material conditions in the

home were good. Mrs. Brown and her husband had manual, semi-skilled employment. All the family had been registered with the small practice in the deprived area for several years, even though they had moved outside the catchment area. Mrs. Brown had a number of chronic health complaints, including depressive illness and gynaecological problems. Mrs. Brown reported having recently experienced many stressful family-related problems that had impacted on her health. There were no health problems in the children reported.

**MP 01-03:** Ms. Campbell was in her early twenties. She lived with her two pre-school aged children in a council flat in an area of high deprivation. Although separated from the child's father, he visits regularly and seems to play an important role in their lives. The local area suffered from generally poor environmental conditions and the home itself was of a materially low standard. Ms. Campbell worked part-time in unskilled employment. She and her children had been registered with the small practice in the area for around ten years. Ms. Campbell claimed to have good health. Her partner had a chronic health problem that had disabled him from an early age and was, at that time, causing the family much concern. Her daughter was reported to be healthy, except for a recurrent ear infection that, sometimes, required urgent attention. No health problems were reported in her son.

**MP 01-04:** Mrs. Douglas was in her early thirties. She lived with her husband and two children (one pre-school child and one primary school-aged child) in a relatively affluent area of the city. However, Mrs. Douglas and her two children

were registered with the small practice in an area of deprivation because, despite moving outside the catchment area, she wanted to remain registered with the known practice. The family owned their home, which was of a materially high standard. Both Mrs. and Mr. Douglas had skilled employment. Mr. Douglas was registered in a large practice in the area of their new home, as he had no previous ties to the small practice. The family was reported to have no health problems.

**Practice M2:** Large practice with six doctors and other practice nursing staff. Relatively deprived practice area: Deprivation score of 1.53 and with a high ranking in the Lothian Health Board list of deprivation. Three of the six doctors were interviewed, including one GP registrar. Four patients were interviewed from this practice, as follows:

**MP 02-01:** Mr. and Mrs. Ewan were in their thirties. They lived together with their primary school-aged child. Mrs. Ewan was six months pregnant at the time of interview. The family lived in a council flat in an area of high deprivation in a locale that had particularly poor environmental conditions. The material standards of their home were also notably poor. All the family were registered with a large practice in the area where Mrs. Ewan had been registered for more than ten years. Mr. Ewan joined the practice more recently for ease of obtaining health care. Neither Mrs. nor Mr. Ewan had employment. Mrs. Ewan had a history of enduring mental health problems and had been hospitalized on a few occasions. She also reported serious family-related problems through her childhood and into adult life. Mr. Ewan had suffered brain damage in an

accident, suffered multiple disabilities and was a wheelchair user. Mrs. Ewan provided twenty-four hour care to her husband. Her child was reported to have no health problems.

**MP 02-02:** Ms. Forrest was in her early twenties. She was a lone parent, living with her one primary school-aged child in a council owned flat in an area of high deprivation. The local area suffered from generally poor environmental conditions and the home itself was of a materially low standard. Ms. Forrest was not employed. She and her child were registered with a large practice in the area. Ms. Forrest suffered from enduring mental health problems that have incapacitated her, at times, and she has been hospitalized on several occasions. Her child was reported to have no health problems. The Health Visitor from the surgery and Social Services played a role in supporting this family.

**MP 02-03:** Mr. George and Ms. Grange were in their early twenties. They lived with their pre-school aged child in an area of high deprivation in a locale with particularly poor environmental conditions. Ms. Grange was six months pregnant at the time of interview. Their home had low material standards and had recently been purchased by them from the council. Mr. George was employed in semi-skilled work. Ms. Grange was not employed. All of the family had been registered with the large practice in the area for three to four years. Ms. Grange was said to enjoy good health. Mr. George reported having good health until recently, when he suffered an episode of illness that debilitated him. No other health problems in the family were reported.

**MP 02-04:** Mr. Hendry and Ms. Hamilton were in their late thirties. They lived in an area of high deprivation with Ms. Hamilton's five school-age children. Their locale suffered poor environmental conditions and their home reflected material hardship. Mr. Hendry and Mrs. Hamilton were unemployed. All the family had been registered with the large practice in the area for over ten years. They reported no health problems in the family, except the youngest son, aged eight, who had a chronic condition. This problem was said to be usually well controlled but became problematic, at times, and would then require urgent attention. No other health problems were reported in the family.

**Practice M3:** Large practice with six doctors and other practice nursing staff. Relatively affluent practice area: Deprivation score of -0.7 and with a low ranking in the Lothian Health Board list of deprivation. All six of the doctors were interviewed. Four patients were interviewed from this practice, as follows:

**MP 03-01:** Mr. Inch and Mrs. Inch were in their early forties/late thirties, respectively. They lived with their three school-age children in an affluent area. Both their locale and home reflected high socio-economic standards. Mr. and Mrs. Inch were in full-time professional employment. All the family was registered with the large practice in the affluent area and had been for more than fifteen years, even though they had moved outside the practice catchment area. Mr. Inch had recently suffered a serious, physical health problem that was reported to have impacted considerably on his life and for which he was still receiving specialist and GP treatment. No other health problems in the family were reported.

**MP 03-02:** Ms. Jackson was in her thirties. She lived with her husband and pre-school child in an affluent area. Both their locale and material condition of their home reflected high socio-economic standards. Ms. and Mr. Jackson were employed full-time in professional occupations. All the family was registered with the large practice in the affluent area and had been for several years, even though they had moved outside the practice catchment area. The family reported having no particular health problems.

**MP 03-03:** Mrs. Kyle was in her early forties. She lived in an affluent area with her husband and one school-age child. Their home was privately owned. Both their locale and material condition of their home reflected high socio-economic standards. Mrs. Kyle worked part-time in a semi-skilled occupation. Her husband was self-employed in a professional occupation. All the family was registered with the large practice in the area and had been for a few years. Mrs. Kyle reported having no particular health problems in the family.

**MP 03-04:** Ms. Leishman was in her late thirties. She lived with her partner and two school-age children in their privately-owned flat in an affluent area. Both Ms. Leishman and her partner worked full-time in professional occupations. Their locale and the material condition of their home reflected relatively high socio-economic standards. All of the family was registered with the large practice in the area since moving house a few years earlier. Ms. Leishman had suffered depressive illness and gynaecological problems in the past. Her



daughter had also recently experienced health problems that required hospitalization.

**Practice M4:** Group practice consisting of four separate practices sharing all administrative functions, allied staff, including reception and nursing staff and an on-site counsellor. Three of the practices were single-handed and one double-handed. Relatively affluent practice area: Deprivation score of -1.8 and with a low ranking in the Lothian Health Board list of deprivation. All five of the doctors were interviewed. Three patients were interviewed from this practice, as follows:

**MP 04-01:** Mrs. Mooney was in her early thirties. She lived with her husband and four school-age children in an affluent area. Their home was privately owned. Both their locale and material condition of their home reflected very high socio-economic standards. Mrs. Mooney was not employed. Her husband worked full-time in a professional occupation. All the family had been registered with a single-handed GP from the affluent area for over twelve years, although they lived then outside the catchment area. Mrs. Mooney reported having some health problems during and after her pregnancies, including suffering depressive illness. No other health problems in the family were reported.

**MP 04-02:** Ms. Nicols was in her early thirties. She was a lone parent, caring for three school-age children in her privately-owned house in the affluent area. She worked part-time in a professional occupation. All the family was registered

with a single-handed GP from an affluent area for over ten years. She reported having no life-threatening or chronic health problems in the family, but had experienced occasions where she and her children had required emergency admissions to hospital or urgent care at home. She also reported recent family stress due to separation and impending divorce.

**MP 04-03:** Mr. and Mrs. O'Neill were in their early thirties. They lived in their privately-owned house in an affluent area with their two pre-school aged children. Mrs. O'Neill was seven months pregnant at the time of interview. Both their locale and material condition of their home reflected high socio-economic standards. Mr. O'Neill worked full-time in a professional occupation. Mrs. O'Neill was not employed. All the family had been registered with the small, double-handed practice in the affluent area for around four years. They reported having no particular health problems in the family.

## **APPENDIX D: Doctors' Approach Letter**

Dear Dr [Name of Doctor]

### **The Meaning and Value of Personal Care in General Practice**

There is a current debate about the provision and importance of personal care in the changing context of general practice. Rather surprisingly, however, there is little information on what doctors and patients mean by the term, and whether or not it is important to them.

We are writing to you and your partner in the practice to ask for your help with this study of *"the meaning and value of personal care in general practice"*. The study is funded by the MRC and follows on from previous research we've done about stress in general practitioners, and complements other on-going research we're doing about what doctors value in their practice, about continuity of care, and about quality of care.

If you agree to take part, you would be asked:

- to talk to our doctoral researcher, Rachel Adam, about your views on personal care.
- to provide a sample of about 20 patients, randomly drawn from the practice register, from which Rachel will select around 5 or 6 to interview.

All interviews will be strictly confidential, and you will not be identified anywhere in our reports or papers. Your patients' confidentiality will also be strictly safeguarded. At the end of the study we will send you a summary of the research and any other reports or papers you request. We hope that the research will contribute to the debate on the place of personal care in modern general practice.

We hope to interview doctors for the study within the next month or two and would be grateful if you could take this request to your next practice meeting for consideration. You are most welcome to contact Mike Porter on 0131 650 9469 or Rachel Adam directly on 0131 650 9460, should you want more information.

Rachel will contact you some time at the beginning of the week *[date]*, and will be happy to send you more information or come to speak to you at your practice about the study.

We have also sent a copy of this letter to your practice manager for administrative purposes.

**Thank you very much for your help.**

Yours sincerely

Mr AMD Porter  
Senior Lecturer

Dr Sally Wyke  
Senior Research Fellow

## **APPENDIX E: Further Information for All Doctors**

### **Study of the Meaning and Value of Personal Care in General Practice**

**Background to the Study:** The personal component of care is often talked about in General Practice as a core value of the service offered by the profession. Historically it has been seen as a defining feature that distinguishes it from other areas of medicine. This study arises from recently expressed concern that societal and organizational changes may be eroding this aspect of care.

Most research into the area of personal care has tended to focus on evaluating the extent to which the doctor is 'patient-centred' against measures such as health outcomes or patient satisfaction levels. This study aims to explore these assumptions shared by this past work that personal care is inherently 'good' and can be defined and measured within the context of the consultation.

**Aim of the Study:** The study aims to explore whether and how 'personal care' is valued by both patients and doctors and what they mean by personal care, and to explore what the factors are that relate to the patient's wish or need for such care.

**Study Design:** Four practices within two areas of the city of Edinburgh are being approached for possible participation. Within each of the two areas one small and one larger practice has been identified in order to give variation of practice size. It is hoped to interview all of the doctors within each practice, totalling around 20 doctors.

It is hoped to select 10 patients from the register of each participating practice and, taking account of the number of those who may not wish to be involved, we aim to interview between 20 to 25 patients in total. These patients will be selected randomly from all families registered with the recruited practices, who have a child aged one to ten.

**What Involvement Means for Doctors and Patients:** For doctors, involvement means being interviewed once on their opinions of personal care in General Practice. It would also mean permitting access to the practice's patient register so that patients may be sampled and approached to request their participation.

For patients, involvement would mean being approached by means of a letter from the researcher asking whether they would be prepared to be involved in the study. An information sheet giving full details about the study, together with a form which they should return if they do not wish to participate will accompany this letter. They will be interviewed twice in order to obtain some greater detail about their opinions on the topic.

It would be helpful if all these interviews could be tape-recorded so that an accurate record of the discussion is obtained. All interviews with both doctors and patients will take up to a maximum of one hour each and will be subject to strict rules of confidentiality and security of information.

**The Value of the Study:** It is hoped that this study may contribute to our understanding of what doctors and patients mean by the notion of personal care in General Practice at a somewhat more detailed level than has previously been examined. Similarly, the study will be of value in helping us to understand what importance it may have for some patients and in what circumstances and context this occurs. Such an understanding would help to inform the debate on the service offered by GPs at an individual consultation level within practices, as well as at an organizational/policy one and could usefully be integrated into undergraduate and vocational training.

The views of patients on this topic are considered to be of particular importance in informing how this aspect of the health service should be provided.

**YOUR HELP IN THIS STUDY WOULD BE GREATLY APPRECIATED.**

## **APPENDIX F: More Information for Participating Practices:**

**Doctors:** It is hoped to interview all the doctors at your practice and, failing this, as many as possible. Each interview would take around 45 minutes.

**Practice:** We also need a random sample of patients from your practice. In practical terms, this will involve:

- Producing a list of all children aged 1 to 10 years from the register and drawing a sample of 20 children from it. To ensure the selection is random, you will need to do a count of how many such children are on the register (x), work out what proportion of the total a sample of twenty is and count each nth child according to that proportion. For instance, if there are 200 such children in total and we want a sample of twenty, you will need to count each 10<sup>th</sup> child and put them onto the sample list.
- These children will need to be linked to their parents by their addresses, as we only want to interview parents.

**If you use GPASS and are happy that I have access to the register, I can do this bit of work to save you time.**

- Those parents would then need to be vetted by the practice for exclusion from the final list before it is given to me. You should exclude:
  - (a) any patient who has indicated s/he does not wish to take part in research
  - (b) any patient known to currently be involved in research
  - (c) any patient whom you feel may be harmed by being involved in the study

In relation to (c), we are keen to speak with as wide a range of patients as possible, including those with health and social problems, so please only exclude those whom you feel may be actively harmed by taking part. As a further safeguard, all patients approached will be given at least three chances to decline involvement in the study themselves.

## **APPENDIX G: Patients' Approach Letter**

Dear [Name of Patient]

**Re: Your Views on Personal Care in General Practice**

Your doctor's surgery has been involved in a study being carried out by the University of Edinburgh. The study is interested in what the idea of getting personal care from the doctor means to patients and doctors and whether it is thought to be of any importance.

I am interested in talking to people about their own and their families' views of care from the doctor. Your name has been randomly selected from the list of all patients on the surgery's register who have at least one child aged one to ten.

I am writing to ask whether I could visit you at home to tell you more about the study and to ask if you are willing to help me with it. Helping would mean talking to me at your home, if convenient, for about an hour on two separate occasions with around two weeks in between. This would give us both a chance to think about what has come up in the first discussion.

*You should know that anything we discuss is entirely confidential and not passed to anyone except those few directly involved in the study at the University. No information is passed back to the surgery about what you have said. You can withdraw from the study at any time.*

I have enclosed an information sheet giving you more details about the study to help you decide. Whatever you do decide about helping me, your care from your practice will not be affected. If you **do not want** to take part, perhaps you would be good enough to complete and return the enclosed form.

If I **do not** hear from you in the next couple of weeks, I will contact you again by phone or by calling in to ask if you could take part.

**Getting patients' opinions of health service care is really important and your participation would be very much appreciated.**

Yours sincerely

Rachel Adam  
(MRC Graduate Research Student)



## **APPENDIX H: Patients' Further Information**

### **YOUR VIEWS ON 'PERSONAL CARE' IN GENERAL PRACTICE**

#### **What is the Aim of the Study?**

This study aims to explore the idea of what having a 'personal doctor' means to people and whether getting 'personal care' from a GP is important or valuable to them. It will involve talking both to doctors and patients about this to get their opinions. Patients' views are particularly important.

#### **Who is Doing the Study?**

The study is being done by Rachel Adam, a research student at Edinburgh University. It is supported and funded by the Medical Research Council.

#### **What does Taking Part in the Study Involve?**

Rachel would like to visit you at home, if convenient, on two separate occasions to talk to you about what personal care means to you. Each visit would take up to an hour and the second would take place about two weeks after the first.

It would be helpful if this conversation could be tape-recorded so that we have an accurate account of what has been discussed.

*You are under no obligation to participate in the study and are free to withdraw at any time. Also, be assured that you do not have to answer any question you'd rather not. Whatever you decide, your care from the doctor will not be affected.*

#### **What Happens to this Information?**

Any information given is treated as strictly confidential. No information will be passed to the practice or your doctor. The only people who will know what you have said are those few directly involved with the study at the University.

You will not be identified by name either on the tapes or in any notes. Your details and all other information will be kept securely in a locked filing cabinet and the tapes will be destroyed at the end of the study in approximately three years time.

A summary of the research will be sent to all participating doctors at the end of the study. In this and in all other written reports your name is not mentioned and no-one will know what you have said.

You are welcome to contact Rachel at the address or phone number given in the attached letter if you want any further information at any time.

You are also welcome to contact Dr. Scott Murray, the Independent Advisor for the study, if you have concerns at any stage. You may contact him at The McKenzie Medical Centre, 20 West Richmond Street, Edinburgh, EH8 9DX or on 0131 667 2955.

**Your help in this study would be much appreciated.**

**APPENDIX I: Practice M3-Refusal/Consent Form**

Dear Dr [Name of Doctor]

*Re: Study on the Meaning and Importance of ‘Personal Care’ in General Practice*

**I give my permission for you to pass on my name, address and telephone number to Rachel Adam so that she can contact me about the above study.**

I understand that I can withdraw from the study at any time and that I don’t have to answer any questions I’d rather not. I also know that the information I give is strictly confidential, will not be passed back to surgery and that the care I receive from my doctor will not be affected by taking part in the study.

☐ **Please tick**

**I do not wish you to pass on my details for this study.**

I understand that refusing to take part in this study will not in any way affect the care I receive from the practice.

☐ **Please tick**

**Name:** .....

**Address:** .....

**Tel No:** .....

**Name: (Please print)**.....

**Signature:** .....

**APPENDIX J: Patients' Refusal Form**

*Re: Study on the Meaning and Importance of 'Personal Care' in General Practice*

I do not want to be contacted again about taking part in this study.

Name: .....

Address: .....

Name (Please print): .....

Signature: .....

**APPENDIX K: Patients' Consent Form**

I agree to participate in this study and am happy to meet with Rachel to discuss my views of 'personal care' in General Practice.

I understand that I can withdraw from the study at any time and that I don't have to answer any questions I'd rather not. I also know that the information I give is strictly confidential and that the care I receive from my doctor will not be affected by taking part in the study.

**Name:** .....

**Address:** .....

**Tel No:** .....

**Name (Please print)**.....

**Signature:** .....

## **APPENDIX L: Patient Interview Information Sheet**

Date(s) of Interview(s):

Name:

Address:

Tel No:

Age:

Occupation:

Practice/Doctor Registered with:

Length of Time at Practice:

Who See at Practice:

Who Else in Family/Mentioned in Interview:

Name:	Relationship:	Occupation:	Age:	HH:
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Any Other Information:

Comments:

**APPENDIX M: Patients' and Doctors Indexing Categories**

NVivo revision 1.1.127      Licensee: RAdam Dept. of General Practice

Project: Personal Care- Patients' and Doctors' Data

NODE LISTING

Nodes in Set: All Nodes  
Created:      7/27/00 - 11:15:53 AM  
Modified:    7/27/00 - 11:15:53 AM  
Number of Nodes: 8

- 1      PC as concept
- 2      Meanings
- 3      Value and Importance
- 4      Knowing
- 5      Benefits and Dis-benefits
- 6      Choice of Practice
- 7      Discourses
- 8      Identity and Legitimacy